CERTIFICATION STANDARDS

FOR

ALCOHOL AND DRUG ABUSE PROGRAMS

Missouri Department of Mental Health
Division of Alcohol and Drug Abuse

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Rules of Department of Mental Health

Division 10–Director, Department of Mental Health
Chapter 7–Core Rules for Psychiatric and Substance Abuse Programs

Chapter 5—General Program Procedures

Division 30–Certification Standards
Chapter 3–Alcohol and Drug Abuse Programs

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 10—Director, Department of Mental Health
Chapter 7—Core Rules for Psychiatric and Substance Abuse Programs

9 CSR 10-7.010 Treatment Principles and Outcomes

PURPOSE: This rule describes treatment principles and outcomes in Alcohol and Drug Abuse Treatment Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs. The performance indicators listed in this rule are examples of how a treatment principle can be met and do not constitute a list of specific requirements. The indicators include not only data that may be compiled by a program but also circumstances that a surveyor may observe or monitor, consumer satisfaction and feedback compiled by the department, and other data that the department may compile and distribute. A program may also use additional or other means to demonstrate achievement of these principles and outcomes.

(1) Applying the Treatment Principles. The organization's service delivery shall apply the key principles listed in this rule in a manner that is:

(A) Adapted to the needs of different populations served;

(B) Understood and practiced by staff in providing services and supports; and

(C) Consistent with clinical studies and practice guidelines for achieving positive outcomes.

(2) Outcome Domains. Services shall achieve positive outcomes in the emotional, behavioral, social and family functioning of individuals. Positive outcomes shall be expected to occur in the following domains:

(A) Safety for the individual and others in his or her environment;

(B) Improved management of daily activities, including the management of the symptoms associated with a psychiatric and/or substance use disorder and also the reduction of distress related to these symptoms;

(C) Improved functioning related to occupational/educational status, legal situation, social and family relationships, living arrangements, and health and wellness; and

(D) Consumer satisfaction with services.

(3) Outcome Measures and Instruments. An organization shall measure outcomes for the individuals it serves and shall collect data related to the domains listed in section (2) of this rule. In order to promote consistency and the wider applicability of outcome data, the department may require, at its option, the use of designated outcome measures and instruments. The required use of particular measures or instruments shall be applicable only to those services funded by the department or provided through a service network authorized by the department.

(4) Essential Treatment Principle—Therapeutic Alliance.

(A) The organization shall promote initial attendance, engagement and development of an ongoing therapeutic alliance by—

1. Treating people with respect and dignity;
2. Enhancing motivation and self-direction through identification of meaningful goals that establish positive expectations;
3. Working with other sources (such as family, guardian or courts) to promote the individual's participation;
4. Addressing barriers to treatment;
5. Providing consumer and family education to promote understanding of services and supports in relationship to individual functioning or symptoms and to promote understanding of individual responsibilities in the process;
6. Encouraging individuals to assume an active role in developing and achieving productive goals; and
7. Delivering services in a manner that is responsive to each individual's age, cultural background, gender, language and communication skills, and other factors, as indicated.

(B) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators of a therapeutic alliance can include, but are not limited to, the following:

1. Convenient hours of operation consistent with the needs and schedules of persons served;
2. Geographic accessibility including transportation arrangements, as needed;
3. Rate of attendance at scheduled services;
4. Individuals consistently reporting that staff listen to and understand them;
5. Treatment dropout rate;
6. Rate of successfully completing treatment goals and/or the treatment episode; and
7. Consumer satisfaction and feedback.

(5) Essential Treatment Principle—Individualized Treatment.

(A) Services and supports shall be individualized in accordance with the needs and situation of each individual served.

(B) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators can include, but are not limited to, the following:

1. There is variability in the type and amount of services that individuals receive, consistent with their needs, goals and progress;
2. There is variability in the length of stay for individuals to successfully complete a level of care or treatment episode, consistent with their severity of need and treatment progress;
3. In structured and intensive levels of care, group education/-counseling sessions are available to deal with special therapeutic issues applicable to some, but not all, individuals;

4. Services on a one-to-one basis between an individual served and a staff member (such as individual counseling and community support) are routinely available and scheduled, as needed; and

5. Individuals consistently report that program staffs are helping them to achieve their personal goals.

(6) Essential Treatment Principle—Least Restrictive Environment.

(A) Services and supports shall be provided in the most appropriate setting available, consistent with the individual's safety, protection from harm, and other designated utilization criteria.

(B) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators can include, but are not limited to the following:

1. Utilization rate of inpatient hospitalization and residential treatment;

2. Length of stay for inpatient and residential treatment;

3. Consistent use of admission/-placement criteria;

4. Distribution of individuals served among levels of care;

5. Consumer satisfaction and feedback.

(7) Essential Treatment Principle—Array of Services.

(A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.

2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.

3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.

4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.

5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals.

(B) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators can include, but are not limited to, the following:

1. Percentages of individuals who complete inpatient or residential treatment and receive continuing services on an outpatient basis;

2. Readmission rates to inpatient or residential treatment;

3. Number of individuals receiving detoxification who continue treatment;

4. Number of individuals who have progressed from more intensive to less intensive levels of care;

5. Feedback from referral sources and other community resources; and

6. Consumer satisfaction and feedback.

(8) Essential Treatment Principle—Recovery.

(A) Services shall promote the independence, responsibility, and choices of individuals.

1. An individual shall be encouraged to achieve positive social, family and occupational/educational functioning in the community to the fullest extent possible.

2. Every effort shall be made to accommodate an individual's schedule, daily activities and responsibilities when arranging services, unless otherwise warranted by factors related to safety or protection from harm.

3. Individuals shall be encouraged to accomplish tasks and goals in an independent manner without undue staff assistance.

(B) Reducing the frequency and severity of symptoms and functional limitations are important for continuing recovery

(C) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators can include, but are not limited to, the following:

1. Measures of symptom frequency and severity;

2. Improved functioning related to—

A. Occupational/educational status;

B. Legal situation;

C. Social and family relationships;

D. Living arrangements; and

E. Health and wellness;

3. Tapering the intensity and frequency of services, consistent with individual progress; and

4. Consumer satisfaction and feedback.

(9) Essential Treatment Principle—Peer Support and Social Networks.

(A) The organization shall mobilize peer support and social networks among those individuals it serves.

1. The organization shall encourage participation in self-help groups.

2. Opportunities and resources in the community are used by individuals, to the fullest extent possible.

(B) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators can include, but are not limited to, the following:

1. Rate of participation in community-based self help groups;

2. Involvement with a wide range of individuals in social activities and networks (such as church, clubs, sporting activities, etc.);

3. Open discussion of therapeutic issues in group counseling and education sessions with individuals giving constructive feedback to one another; and

4. Consumer satisfaction and feedback.

(10) Essential Treatment Principle—Family Involvement.

(A) Efforts shall be made to involve family members, whenever appropriate, in order to promote positive relationships.

1. Family ties and supports shall be encouraged in order to enrich and support recovery goals.

2. Family members shall be routinely informed of available services, and the program shall demonstrate the ability to effectively engage family members in a recovery process.

3. When the family situation has been marked by circumstances that may jeopardize safety (such as domestic violence, child abuse and neglect, separation and divorce, or financial and legal difficulties), family members shall be encouraged to participate in education and counseling sessions to better understand these effects and to reduce the risk of further occurrences.

(B) Particular emphasis on family involvement shall be demonstrated by those programs serving adolescents and children.

(C) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators can include, but are not limited to, the following:

1. Rate of family participation in treatment planning;

2. Rate of family participation in direct services, such as family therapy;

3. Improved family relationships;

4. Reduction of family conflict; and

5. Satisfaction of family members with services.

(11) Pharmacological Treatment. When clinically indicated for the person served, pharmacological treatment shall be provided or arranged to ameliorate psychiatric and substance abuse problems.

(12) Co-Occurring Disorders. For individuals with clearly established co-occurring disorders, coordinated services for these disorders shall be provided or arranged.

(A) Each individual shall have access to a full range of services provided by qualified, trained staff.

(B) Each individual shall receive services necessary to fully address his/her treatment needs. The program providing screening and assessment shall—

1. Directly provide all necessary services in accordance with the program's capabilities and certification;

2. Make a referral to a program which can provide all necessary services and maintain appropriate involvement until the individual is admitted to the other program; or

3. Provide those services within its capability and promptly arrange additional services from another program.

(C) Services shall be continuously coordinated between programs, where applicable. Programs shall—

1. Ensure that services are not redundant or conflicting; and

2. Maintain communication regarding the individual's treatment plan and progress.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10-7.020 Rights, Responsibilities, and Grievances

PURPOSE: This rule describes the rights of individuals being served and grievance procedures in Alcohol and Drug Abuse Treatment Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.

(1) General Policy and Practice. The organization shall demonstrate through its policies, procedures and practices an ongoing commitment to the rights, dignity, and respect of the individuals it serves. In addition to the requirements of this rule, the organization must also comply with 9 CSR 10-5.200 regarding protection from abuse and neglect and investigations of any such allegations.

(2) Information and Orientation. Immediately upon admission, each individual shall be informed and oriented as to what will happen as care and treatment are provided.

(A) An individual who is admitted on a voluntary basis shall be expected to give written, informed consent to care and treatment.

(B) The orientation given to each individual shall address service costs, availability of crisis assistance, rights, responsibilities, and grievance procedures.

1. Information regarding responsebilities shall include applicable program rules, participation requirements or other expectations.

2. Information regarding grievance procedures shall include how to file a grievance, time frames, rights of appeal, and notification of outcome.

3. Each client shall be given the name, address and phone number of the department's client rights monitor and informed that the monitor may be

contacted regarding a complaint of abuse, neglect or violation of rights.

(C) The orientation information shall be provided in written form using simple, straightforward language understandable to the individual and explained by staff as necessary.

(D) When appropriate, families receive information to promote their participation in or decisions about care and treatment.

(3) Rights Which Cannot Be Limited. Each individual has basic rights to humane care and treatment that cannot be limited under any circumstances.

(A) The following rights apply to all settings:

1. To receive prompt evaluation, care and treatment;
2. To receive these services in the least restrictive environment;
3. To receive these services in a clean and safe setting;
4. To not be denied admission or services because of race, gender, sexual preference, creed, marital status, national origin, disability or age;
5. To confidentiality of information and records in accordance with federal and state law and regulation;
6. To be treated with dignity and addressed in a respectful, age appropriate manner;
7. To be free from abuse, neglect, corporal punishment and other mistreatment such as humiliation, threats or exploitation;
8. To be the subject of an experiment or research only with one's informed, written consent, or the consent of an individual legally authorized to act;
9. To medical care and treatment in accordance with accepted standards of medical practice, if the certified substance abuse or psychiatric program offers medical care and treatment; and
10. To consult with a private, licensed practitioner at one's own expense.

(B) The following additional rights apply to residential settings, and where otherwise applicable, and shall not be limited under any circumstances:

1. To a nourishing, well-balanced, varied diet;
2. To attend or not attend religious services;
3. To communicate by sealed mail with the department and, if applicable, legal counsel and court of jurisdiction;
4. To receive visits from one's attorney, physician or clergy in private at reasonable times; and
5. To be paid for work unrelated to treatment, except that an individual may be expected to perform limited tasks and chores within the program that are designed to promote personal involvement and responsibility, skill building or peer support. Any tasks and chores beyond routine care and cleaning of activity or bedroom areas within the program must be directly related to recovery and treatment plan goals developed with the individual.

(4) Rights Subject to Limitation. Each individual shall have further rights and privileges, which can be limited only to ensure personal safety or the safety of others.

(A) Any limitation due to safety considerations shall occur only if it is—

1. Applied on an individual basis;
2. Authorized by the organization's director or designee;
3. Documented in the individual's record;
4. Justified by sufficient documentation;
5. Reviewed on a regular basis at the time of each individualized treatment plan review; and
6. Rescinded at the earliest clinically appropriate moment.

(B) In all care and treatment settings, each individual shall have the right to see and review one's own record, except that specific information or records provided by other individuals or agencies may be excluded from such review. The organization may require a staff member to be present whenever an individual accesses the record.

(C) The following additional rights and privileges apply to individuals in residential settings, and where otherwise applicable:

1. To wear one's own clothes and keep and use one's own personal possessions;
2. To keep and be allowed to spend a reasonable amount of one's own funds;
3. To have reasonable access to a telephone to make and to receive confidential calls;
4. To have reasonable access to current newspapers, magazines and radio and television programming;
5. To be free from seclusion and restraint;
6. To have opportunities for physical exercise and outdoor recreation;
7. To receive visitors of one's choosing at reasonable hours; and
8. To communicate by sealed mail with individuals outside the facility.

(5) Other Legal Rights. The organization shall ensure that all individuals have the same legal rights and responsibilities as any other citizen, unless otherwise limited by law.

(6) Access to Services. An individual shall not be denied admission or services solely on the grounds of prior treatment, withdrawal from treatment against advice, or continuation or return of symptoms after prior treatment.

(7) Grievances. The organization shall establish policies, procedures and practices to ensure a prompt, responsive, impartial review of any grievance or alleged violation of rights.

(A) Reasonable assistance shall be given to an individual wishing to file a grievance.

(B) The review shall be consistent with principles of due process.

(C) The organization shall cooperate with the department in any review or investigation conducted by the department or its authorized representative.

(8) Practices to Promote Safety and Well-Being. The organization shall demonstrate a commitment to the safety and well-being of the individuals it serves. The organization's policies, procedures and practices shall—

(A) Promote therapeutic progress by addressing matters such as medication compliance, missed appointments, use of alcohol and drugs, and other program expectations or rules;

(B) Encourage appropriate behavior by providing positive instruction and guidance; and

(C) Ensure safety by effectively responding to any threats of suicide, violence or harm. Any use of seclusion or restraint shall be in accordance with 9 CSR 10-7.060 Behavior Management.

(9) All certified agencies, upon learning of the death of a client receiving services, must report the death to the Department of Mental Health (DMH) within twenty-four (24) hours. DMH report form 9719 shall be completed and faxed to the appropriate division director.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Dec. 12, 2001, effective June 30, 2002. Amended: Filed July 29, 2002, effective March 30, 2003.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10-7.030 Service Delivery Process and Documentation

PURPOSE: This rule describes requirements for the delivery and documentation of services in Alcohol and Drug Abuse Treatment Programs, Comprehensive Substance Treatment and Rehabilitation (CSTAR), Compulsive Gambling Treatment Programs, Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.

(1) Screening. Each individual requesting service shall have prompt access to a screening in order to determine eligibility and to plan an initial course of action, including referral to other services and resources, as needed.

(A) At the individual's first contact with the organization (whether by telephone or face-to-face contact), any emergency or urgent service needs shall be identified and addressed.

1. Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. A person who presents at the program site with emergency service needs shall be seen by a qualified staff member within fifteen (15) minutes of presentation. If emergency service needs are reported by telephone, the program shall initiate face-to-face contact within one (1) hour of telephone contact or shall immediately notify local emergency personnel capable of promptly responding to the report.

2. Urgent service needs are indicated when a person presents a significant impairment in the ability to care for self but does not pose a likelihood of immediate harm to self or others. A person with urgent service needs shall be seen within forty-eight (48) hours, or the program shall provide information about treatment alternatives or community supports where available.

3. Routine service needs are indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. A person with routine service needs should be seen as soon as possible to the extent that resources are available.

(B) The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.

(C) The screening—

1. Shall be conducted by trained staff;

2. Shall be responsive to the individual's request and needs; and

3. Shall include notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community.

(2) Assessment and Individualized Treatment Plan. Each individual shall participate in an assessment that more fully identifies their needs and goals and develops an individualized plan. The participation of family and other collateral parties (e.g., referral source, employer, school, other community agencies) in assessment and individualized plan development shall be encouraged, as appropriate to the age, guardianship, services provided or wishes of the individual.

(A) The assessment shall assist in ensuring an appropriate level of care, identifying necessary services, and developing an individualized treatment plan. The assessment data shall subsequently be used in determining progress and outcomes. Documentation of the screening and assessment must include, but is not limited to, the following:

1. Demographic and identifying information;

2. Statement of needs, goals and treatment expectations from the individual requesting services. The family's perceptions are also obtained, when appropriate and available;

3. Presenting situation/problem and referral source;

4. History of previous psychiatric and/or substance abuse treatment including number and type of admissions;

5. Health screening;

6. Current medications and identification of any medication allergies and adverse reactions;

7. Recent alcohol and drug use for at least the past thirty (30) days and, when indicated, a substance use history that includes duration, patterns, and consequences of use;

8. Current psychiatric symptoms;

9. Family, social, legal, and vocational/educational status and functioning. The collection and assessment of historical data is also required, unless short-term crisis intervention or detoxification are the only services being provided;

10. Current use of resources and services from other community agencies;

11. Personal and social resources and strengths, including the availability and use of family, social, peer and other natural supports; and

12. Multi-axis diagnosis or diagnostic impression in accordance with the current edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association.

(B) Recommendations for specialized services may require more extensive diagnostic testing.

(C) Each person shall directly participate in developing his/her individualized treatment plan including, but not limited to, signing the treatment plan.

(D) The individualized treatment plan shall reflect the person's unique needs and goals. The plan shall include, but is not limited to, the following:

1. Measurable goals and outcomes;
2. Services, supports and actions to accomplish each goal/outcome. This includes services and supports and the staff member responsible, as well as action steps of the individual and other supports (family, social, peer, and other natural supports);
3. Involvement of family, when indicated;
4. Service needs beyond the scope of the organization or program that are being addressed by referral or services at another community organization, where applicable;
5. Projected time frame for the completion of each goal/outcome; and
6. Estimated completion/discharge date for the level of care.

(3) Ongoing Service Delivery. The individualized treatment plan shall guide ongoing service delivery. However, services may begin before the assessment is completed and the plan is fully developed.

(A) Services shall be provided in accordance with applicable eligibility and utilization criteria. Criteria specified in program rules shall be incorporated into the treatment process, applied to each individual, and used to guide the intensity, duration, and type of services provided. Decisions regarding the level of care and the treatment setting shall be based on—

1. Personal safety and protection from harm;
2. Severity of the psychiatric or substance abuse problem;
3. Emotional and behavioral functioning and need for structure;
4. Social, family and community functioning;
5. Readiness and social supports for recovery;
6. Ability to avoid high risk behaviors; and
7. Ability to cooperate with and benefit from the services offered.

(B) Services shall be appropriate to the individual's age and development and shall be responsive to the individual's social/cultural situation and any linguistic/communication needs.

(C) There is a designated staff member who coordinates services and ensures implementation of the plan. Coordination of care shall also be demonstrated when services and supports are being provided by multiple agencies or programs.

(D) To the fullest extent possible, individuals shall be responsible for action steps to achieve their goals. Services and supports provided by staff shall be readily available to encourage and assist the individuals in their recovery.

(E) Services and supports shall be provided by staff with appropriate licenses or credentials.

(4) Crisis Assistance and Intervention. During the course of service delivery, ready access to crisis assistance and intervention is available, when needed. The organization shall provide or arrange crisis assistance twenty-four (24) hours per day, seven (7) days per week which is provided by qualified staff in accordance with any applicable program rules and includes face-to-face intervention, when clinically indicated.

(5) Missed Appointments. Agencies shall establish policies and procedures, consistent with needs and requirements of clients, to contact persons who fail to appear at a scheduled program activity.

(A) Such efforts should be initiated within forty-eight (48) hours, unless circumstances indicate a more immediate contact should be made due to the person's symptoms and functioning or the nature of the scheduled service.

(B) Efforts to contact the person shall be documented in the individual's record.

(6) Reviewing Treatment Goals and Outcomes. Progress toward treatment goals and outcomes shall be reviewed on a periodic basis.

(A) Each person shall directly participate in the review of their individualized treatment plan.

(B) The frequency of treatment plan reviews shall be based on the individual's level of care or other applicable program rules. The occurrence of a crisis or significant clinical event may require a further review and modification of the treatment plan.

(C) The individualized treatment plan shall be updated and changed as indicated.

(7) Effective Practices. Service delivery shall be consistent with the current state of knowledge and generally accepted practices in the following areas:

(A) Support of personal recovery process which addresses clinical issues such as overcoming denial, recognizing feelings and behavior, encouraging personal responsibility, and constructively using leisure time;

(B) Provision of information and education about the person's disorder(s), principles and availability of self-help groups, and health and nutrition;

(C) Skill development which addresses clinical issues such as communication, stress reduction and management, conflict resolution, decision making, assertiveness and parenting;

(D) Promotion of positive family relationships; and

(E) Relapse prevention.

(8) Clinical Utilization Review. Services may be subject to clinical utilization review when funded by the department or provided through a service network authorized by the department. Clinical utilization review shall promote the delivery of services that are necessary, appropriate, likely to benefit the individual and provided in accordance with admission criteria and service definitions.

(A) The department shall have authority in all matters subject to clinical utilization review including client eligibility and service definition, authorization and limitations.

(B) Clinical utilization review may be required of any individual's situation and needs prior to initial or continued service authorization.

(C) Clinical utilization review shall include, but is not limited to, unusual patterns of service or utilization for individual clients based on periodic data analysis and norms compiled by the department.

(D) Clinical utilization review may include, but is not limited to, the following situations regarding a program:

1. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by the department regarding the use of particular services and total service cost; and

2. Compliance issues related to certification standards or contract requirements that can reasonably be monitored through clinical utilization review.

(E) Staff who conducts clinical utilization review shall be credentialed with relevant professional experience.

(9) Discharge Summary and Aftercare Plan. Each individual shall be actively involved in planning for discharge and aftercare. The participation of family and other collateral parties (e.g., referral source, employer, school, other community agencies) in such planning shall be encouraged, as appropriate to the age, guardianship, service provided or wishes of the individual.

(A) A written discharge summary and, where applicable, an aftercare plan shall be prepared upon—

1. Transferring to a different provider;

2. Successfully completing treatment; or

3. Discontinuing further participation in services.

(B) A discharge summary shall include, but is not limited to, the following:

1. Dates of admission and discharge;

2. Reason for admission and referral source;

3. Diagnosis or diagnostic impression;

4. Description of services provided and outcomes achieved, including any prescribed medication, dosage, and response;

5. Reason for or type of discharge; and

6. Medical status and needs that may require ongoing monitoring and support.

(C) An aftercare plan shall be completed prior to discharge. The plan shall identify services, designated provider(s), or other planned activities designed to promote further recovery.

(D) The organization shall consistently implement criteria regarding discharge or successful completion; termination or removal from the program; and readmission following discharge or termination.

(10) Designated or Required Instruments. In order to promote consistency in clinical practice, eligibility determination, service documentation, and outcome measurement, the department may require the use of designated instruments in the screening, assessment and treatment process. The required use of particular instruments shall be applicable only to those services funded by the department or provided through a service network authorized by the department.

(11) Organized Record System. The organization has an organized record system for each individual.

(A) Records shall be maintained in a manner which ensures confidentiality and security.

1. The organization shall abide by all local, state and federal laws and regulations concerning the confidentiality of records.

2. If records are maintained on computer systems, there must be a backup system to safeguard records in the event of operator or equipment failure and to ensure security from inadvertent or unauthorized access.

3. The organization shall retain individual records for at least five (5) years or until all litigation, adverse audit findings, or both, are resolved.

4. The organization shall assure ready access to the record by authorized staff and other authorized parties including department staff.

(B) All entries in the individual record shall be legible, clear, complete, accurate and recorded in a timely fashion. Entries shall be dated and authenticated by the staff member providing the service, including name and title. Any errors shall be marked through with a single line, initialed and dated.

(C) There shall be documentation of services provided and results accomplished. Documentation shall be made with indelible ink or print.

(D) The documentation of services funded by the department or provided through a service network authorized by the department shall include the following:

1. Description of the specific service provided;

2. The date and actual time (beginning and ending times) the service was rendered;

3. Name and title of the person who rendered the service;

4. The setting in which the service was rendered;

5. The relationship of the services to the individual treatment plan; and

6. Description of the individual's response to services provided.

(E) The record of each person served shall include documentation of screening, consent to treatment, orientation, assessment, diagnostic interview, individualized treatment plan and reviews, service delivery and progress reports, and discharge summary with plans for continuing recovery. Where applicable, the record shall also include documentation of referrals to other services or community resources and the outcome of these referrals, signed authorization to release confidential information, missed appointments and efforts to reengage the individual, urine drug screening or other toxicology reports, and crisis or other significant clinical events.

(12) Service System Reporting. For those services funded by the department or provided through a service network

authorized by the department, the organization shall provide information to the department which includes, but is not limited to, admission and demographic data, services provided, costs, outcomes, and discharge or transfer information.

(A) The organization shall maintain equipment and capabilities necessary for this purpose.

(B) The organization shall submit information in a timely manner. Information regarding discharge or transfer shall be submitted within the following time frames:

1. Within fifteen (15) days of discharge or transfer from residential or inpatient status;
2. Within thirty (30) days of completing outpatient treatment in a planned manner; and
3. Within one hundred eighty (180) days of the date of last outpatient service delivery if the individual discontinues services in an unplanned manner.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Dec. 12, 2001, effective June 30, 2002.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10–7.040 Quality Improvement

PURPOSE: This rule describes requirements for quality improvement activities in Alcohol and Drug Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.

(1) The organization develops and implements a written plan for a systematic quality assessment and improvement process that is accountable to the governing body and addresses those programs and services certified by the department.

(A) An individual or committee is designated as responsible for coordinating and implementing the quality improvement plan.

(B) Direct service staff and consumers are involved in the planning, design, implementation and review of the organization's quality improvement activities.

(C) Records and reports of quality improvement activities are maintained.

(D) The organization updates its plan for quality assessment and improvement at least annually.

(2) Data are collected to assess quality, monitor service delivery processes and outcomes, identify opportunities for improvement, and monitor improvement efforts.

(A) Data collection shall reflect priority areas identified in the plan.

(B) Consumer satisfaction data shall be included as part of the organization's quality assessment and improvement process. Such data must be collected in a manner that promotes participation by all consumers.

(C) Data are systematically aggregated and analyzed on an ongoing basis.

(D) Data collection analyses are performed using valid, reliable processes.

(E) The organization compares its performance over time and with other sources of information.

(F) Undesirable patterns in performance and sentinel events are intensively analyzed.

(3) The organization develops and implements strategies for service improvement, based on the data analysis.

(A) The organization evaluates the effectiveness of those strategies in achieving improved services delivery and outcomes.

(B) If improved service delivery and outcomes have not been achieved, the organization revises and implements new strategies.

(4) The department may require, at its option, the use of designated measures or instruments in the quality assessment and improvement process, in order to promote consistency in data collection, analysis, and applicability. The required use of particular measures or instruments shall be applicable only to those programs or services funded by the department or provided through a service network authorized by the department.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10–7.050 Research

PURPOSE: This rule establishes standards and procedures for conducting research in Alcohol and Drug Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.

(1) General Policy. The organization shall have a written policy regarding research activities involving individuals served. The organization may prohibit research activities.

(2) Policies and Practices in Conducting Research. If research is conducted, the organization shall assure that—

(A) Compliance is maintained with all federal, state and local laws and regulations concerning the conduct of research including, but not limited to, sections 630.192, 630.199, 630.194, and 630.115, RSMo, 9 CSR 60-1.010 and 9 CSR 60-1.015;

(B) Participating individuals are not the subject of experimental research without their prior written and informed consent or that of their parents or guardian, if minors;

(C) Participating individuals understand that they may decide not to participate or may withdraw from any research at any time for any reason.

(3) Notice to the Department. If any participating individual is receiving services funded by the department or provided through a service network authorized by the department, the organization shall assure that the research has the prior approval of the department. The organization shall immediately inform the department of any adverse outcome experienced by an individual served due to participation in a research project.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10-7.060 Behavior Management

PURPOSE: This rule establishes requirements for the use of restraint, seclusion and time out in Alcohol and Drug Abuse Treatment Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.

(1) General Policy. Any behavior management methods used by an organization shall promote the rights, dignity and safety of individuals being served. An organization may prohibit by policy and practice the use of behavior management, including physical, mechanical and chemical restraint; seclusion; time out; and the use of behavior management plans for selected individuals. If any of these methods of behavior management are to be used within the organization, it shall develop policies and procedures which define, describe and limit the conditions and circumstances of their use.

(A) Organizations utilizing seclusion and restraint must obtain a separate written authorization from the appropriate division of the Department of Mental Health, in addition to other requirements of this rule. The department may issue such authorization on a time-limited basis subject to renewal.

(B) The organization must prohibit by policy and practice:

1. Aversive conditioning of any kind. Aversive conditioning is defined as the application of startling, unpleasant or painful stimulus or stimuli that have a potentially noxious effect on an individual in an effort to decrease maladaptive behavior;
2. Withholding of food, water or bathroom privileges;
3. Painful stimuli;
4. Corporal punishment; and
5. Use of seclusion, restraint, time out, discipline or coercion for staff convenience.

(C) Behavior management policies and procedures shall be:

1. Approved by the organization's board of directors;
2. Made available to all program employees and providers;
3. Made available to the individuals served, their families and others upon request;
4. Developed with the participation of the individuals and, whenever possible, their family members or advocates, or both; and
5. Consistent with department rules regarding individual rights.

(2) Seclusion and Restraint.

(A) The organization shall assure that seclusion and restraint are only used when an individual's behavior presents an immediate risk of danger to themselves or others and no other safe or effective treatment intervention is possible. They shall only be implemented when alternative, less restrictive interventions have failed or cannot be safely implemented. Seclusion and restraint are never used as a treatment intervention. They are emergency/-security measures to maintain safety when all other less restrictive interventions are inadequate.

(B) Seclusion and restraint shall only be implemented by competent, trained staff.

(C) The organization shall assure that seclusion or restraint is used only when ordered by a licensed practitioner trained in the use of emergency safety interventions or a certified substance abuse counselor trained in the use of emergency safety interventions. Orders for seclusion or restraint must define specific time limits. Seclusion and restraint shall be ended at the earliest possible time.

1. If seclusion or restraint is initiated prior to obtaining an order, staff must obtain an order immediately.
2. Within one (1) hour of the initiation of the seclusion or restraint a certified substance abuse counselor or licensed practitioner trained in the use of emergency safety interventions and assessment of the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well-being of the resident, including but not limited to:
   A. The resident's physical and psychological status;
   B. The resident's behavior;
   C. The appropriateness of the intervention measures; and
   D. Any complications resulting from the intervention.
3. Standing or *pro re nata* (PRN) orders for seclusion or restraint are not allowed.
4. An order cannot exceed four (4) hours for adults, two (2) hours for children and adolescents ages nine to seventeen (9–17), or one (1) hour for children under age nine (9). When non-licensed staff initiates seclusion or restraint, an order based on a face-to-face evaluation must be obtained from a licensed practitioner trained in the use of

emergency safety interventions or a certified substance abuse counselor trained in the use of emergency safety interventions within one (1) hour.

5. Individuals in restraint shall be monitored continuously. Monitoring may be face-to-face by assigned staff or by audiovisual equipment.

6. Individuals in seclusion shall be visually monitored at least every fifteen (15) minutes.

7. Individuals in seclusion or restraint are offered regular food, fluid and an opportunity to meet their personal hygiene needs no less than every two (2) hours.

8. The need for continuing seclusion or restraint shall be evaluated by and, where necessary, re-ordered by a licensed practitioner trained in the use of emergency safety interventions or certified substance abuse counselor trained in the use of emergency safety interventions at least every four (4) hours for adults, two (2) hours for children and adolescents ages nine through seventeen inclusively (9–17), or one (1) hour for children under age nine (9).

9. The evaluation for the first renewal following an order based on a face-to-face evaluation by a licensed practitioner trained in the use of emergency safety interventions or certified substance abuse counselor trained in the use of emergency safety interventions may be based on a telephone consultation between a licensed practitioner trained in the use of emergency safety interventions or a certified substance abuse counselor trained in the use of emergency safety intervention and on-site staff who have done a face-to-face evaluation with the person in seclusion or restraint. The evaluation for every alternate renewal period shall be based on face-to-face observation and/or interview with the individual by the licensed practitioner or certified substance abuse counselor trained in the use of emergency safety interventions.

10. The organization's clinical director or quality improvement coordinator shall review every episode of seclusion or restraint within seventy-two (72) hours.

11. Any incident of restraint or seclusion shall be promptly reported to the person's parent or legal guardian, when applicable.

(3) Individualized Behavioral Management Plan.

(A) Definitions. The following terms shall mean:

1. Behavioral management plan, array of positive and negative reinforcement to reduce unacceptable or maladaptive interactions and behaviors;

2. Time out, an individual's voluntary compliance with the request to remove himself or herself from a service area to a separate location.

(B) The need for a behavioral management plan shall be evaluated upon—

1. Any incident of seclusion or restraint;

2. The use of time-out two (2) or more times per day; or

3. The use of time-out three (3) or more times per week.

(C) Behavioral plan shall include the input of the individual being served and family, if appropriate.

(D) The plan shall identify what the individual is attempting to communicate or achieve through the maladaptive behavior before identifying interventions to change it.

(E) The plan shall be reevaluated within the first seven (7) calendar days and every seven (7) days thereafter to determine whether maladaptive and unacceptable behaviors are being reduced and more functional alternatives acquired.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed April 15, 2002, effective Nov. 30, 2002.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10-7.070 Medications

PURPOSE: This rule describes training and procedures for the proper storage, use and administration of medications in Alcohol and Drug Abuse Treatment Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.

(1) General Guidelines, Policies and Practices. The following requirements apply to all programs, where applicable.

(A) The organization shall assure that staff authorized by the organization and by law to conduct medical, nursing and pharmaceutical services do so using sound clinical practices and following all applicable state and federal laws and regulations.

(B) The organization shall have written policies and procedures on how medications are prescribed, obtained, stored, administered and disposed.

(C) The organization shall implement policies that prevent the use of medications as punishment, for the convenience of staff, as a substitute for services or other treatment, or in quantities that interfere with the individual's participation in treatment and rehabilitation services.

(D) The organization shall allow individuals to take prescribed medication as directed.

1. Individuals cannot be denied service due to taking prescribed medication as directed. If the organization believes that a prescribed medication is subject to abuse or could be an obstacle to other treatment goals, then the organization's treatment staff shall attempt to engage the prescribing physician in a collaborative discussion and treatment planning process. If the prescribing physician is non-responsive, a second opinion by another physician may be used.

2. Individuals shall not be denied service solely due to not taking prescribed medication as directed. However, a person may be denied service if he or she is unable to adequately participate in and benefit from the service offered due to not taking medication as directed.

(2) Medication Profile. Where applicable, the individual's record shall include a medication profile that includes name, age, weight, current diagnosis, current medication and dosage, prescribing physician, allergies to medication, non-prescription medication and supplements, medication compliance; and other pertinent information related to the individual's medication regimen.

(3) Prescription of Medication. If a program prescribes medications, there shall be documentation of each medication service episode including description of the individual's presenting condition and symptoms, pertinent medical and psychiatric findings, other observations, response to medication, and action taken.

(4) Medication Administration and Related Requirements. The following requirements apply to programs that prescribe or administer medication and to those programs where individuals self-administer medication under staff observation.

(A) Staff Training and Competence. The organization shall ensure the training and competence of staff in the administration of medication and observation for adverse drug reactions and medication errors, consistent with each staff individual's job duties.

1. Staff whose duties include the administration of medication shall complete Level I medication aide training in accordance with 19 CSR 30-84.030. This requirement shall not apply to those staff who—

A. Have prior education and training which meets or exceeds the Level I medication aide training hours and skill objectives; or

B. Work in settings where clients self-administer their own medication under staff observation.

2. Staff whose duties are limited to observing clients self-administer their own medication or to documenting that medication is taken as prescribed shall have available to them a physician, pharmacist, registered nurse or reference material for consultation regarding medications and their actions, possible side effects, and potential adverse reactions.

3. Staff whose duties are limited to observing clients self-administer their own medication or to documenting that medication is taken as prescribed shall receive education on general actions, possible side effects, and potential adverse reactions to medications.

(B) Education. If medication is part of the treatment plan, the organization shall document that the individual and family member, if appropriate, understands the purpose and side effects of the medication.

(C) Compliance. The program shall take steps to ensure that each individual takes medication as prescribed and the program shall document any refusal of medications. A licensed physician shall be informed of any ongoing refusal of medication.

(D) Medication Errors. The program shall establish and implement policies defining the types of medication errors that must be reported to a licensed physician.

(E) Adverse Drug Reactions. A licensed physician shall be immediately notified of any adverse reaction. The type of reaction, physician recommendation and subsequent action taken by the program shall be documented in the individual's record.

(F) Records and Documentation. The organization shall maintain records to track and account for all prescribed medications in residential programs and, where applicable, in nonresidential programs.

1. Each individual receiving medication shall have a medication intake sheet which includes the individual's name, known allergies, type and amount of medication, dose and frequency of administration, date and time of intake, and name of staff that administered or observed the medication intake. If medication is self-administered, the individual shall sign or initial the medication intake sheet.

2. The amount of medication originally present and the amount remaining can be validated by the medication intake sheet.

3. Documentation of medication intake shall include over-the-counter products.

4. Medication shall be administered in single doses to the extent possible.

5. The organization shall establish a mechanism for the positive identification of individuals at the time medication is dispensed, administered or self-administered under staff observation.

(G) Emergency Situations. The organization's policies shall address the administration of medication in emergency situations.

1. Medical/nursing staff shall accept telephone medication orders only from physicians who are included in the organization's list of authorized physicians and who are known to the staff receiving the orders. A physician's signature shall authenticate verbal orders within five (5) working days of the receipt of the initial telephone order.

2. The organization may prohibit telephone medication orders, if warranted by staffing patterns and staff credentials.

(H) Periodic Review. The organization shall document that individuals' medications are evaluated by qualified staff at least every six (6) months to determine their continued effectiveness.

(I) Individuals Bringing Their Own Medication. Any medication brought to the program by an individual served is allowed to be administered or self-administered only when the medication is appropriately labeled.

(J) Labeling. All medication shall be properly labeled. Labeling for each medication shall include drug name, strength, dispense date, amount dispensed, directions for administration, expiration date, name of individual being served, and name of the prescribing physician.

(K) Storage. The organization shall implement written policies and procedures on how medications are to be stored.

1. The organization shall establish a locked storage area for all medications that provides suitable conditions regarding sanitation, ventilation, lighting and moisture.

2. The organization shall store ingestible medications separately from non-ingestible medications and other substances.

3. The organization shall maintain a list of personnel who have been authorized access to the locked medication area and who are qualified to administer medications.

(L) Inventory. Where applicable, the organization shall implement written policies and procedures for:

1. Receipt and disposition of stock pharmaceuticals must be accurately documented;

2. A log shall be maintained for each stock pharmaceutical that documents receipts and disposition;

3. At least quarterly, each stock pharmaceutical shall be reconciled as to the amount received and the amount dispensed; and

4. A stock supply of a controlled substance must be registered with the Drug Enforcement Administration and the Missouri Department of Health, Bureau of Narcotics and Dangerous Drugs.

(M) Disposal. The organization shall implement written procedures and policies for the disposal of medication.

1. Medication must be removed on or before the expiration date and destroyed.

2. Any medication left by an individual at discharge shall be destroyed within thirty (30) days.

3. The disposal of all medications shall be witnessed and documented by two (2) staff members.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed April 15, 2002, effective Nov. 30, 2002.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10–7.080 Dietary Service

PURPOSE: This rule establishes dietary and food service requirements in Alcohol and Drug Abuse Treatment Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Pro-grams.

(1) Dietary Standards for Programs with an Incidental Dietary Component.

(A) Programs defined as having only an incidental dietary component shall include:

1. A permanent residence serving no more than four (4) individuals; or

2. Programs and service sites that do not provide for the preparation, storage or provision of food including food brought by the individuals being served.

(B) Programs and service sites defined as having only an incidental dietary component shall address diet and food preparation on a person's individualized treatment plan, if it is identified as an area in need of intervention based on the assessment.

(C) Where the program does not provide meals, but individuals are allowed to bring their own food, the following standards apply:

1. All appliances must be clean and in safe and proper operating condition; and

2. Hand washing facilities including hot and cold water, soap and hand drying means shall be readily accessible.

(2) Dietary Standards for Programs and Treatment Sites with Minimal Dietary Component.

(A) A program or service site shall be defined as having a minimal dietary component if one of the following criteria applies and it does not meet the definition of incidental dietary component:

1. It provides for the preparation, storage or consumption of no more than one (1) meal a day; or

2. The program or service site has an average length of stay of less than five (5) days.

(B) The following standards apply for programs with a minimal dietary component:

1. Meals shall be nutritious, balanced and varied based on the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The practical application of these recommendations can be met by following the Dietary Guidelines for Americans and the Food Guide Pyramid of U.S. Department of Agriculture and the U.S. Department of Health and Human Services;

2. Special diets for medical reasons must be provided;

3. Menus shall be responsive to the cultural and religious beliefs of individuals;

4. Food will be served at realistic meal times in a pleasant, relaxed dining area;

5. Food will be stored safely, appropriately and sanitarily;

6. Food shall be in sound condition, free from spoilage, filth or other contamination and safe for human consumption;

7. All appliances shall be in safe and proper operating condition;

8. Food preparation areas will be cleaned regularly and kept in good repair. Utensils shall be sanitized according to Missouri Department of Health standards;

9. Hand washing facilities that include hot and cold water, soap and a means of hand drying shall be readily available; and

10. Paragraphs 5.–9. of this subsection shall be met if the site has a current inspection in compliance with 19 CSR 20-1.010.

(3) Dietary Standards for Programs and Treatment Sites with a Substantial Dietary Component.

(A) Programs with a substantial dietary component shall be defined as meeting one of the following criteria and are not the permanent residence of more than four (4) individuals:

1. Programs or treatment sites that serve more than one (1) meal per day; and

2. Programs or treatment sites with an average length of stay of over five (5) days.

(B) Programs with a substantial dietary component shall have the following:

1. An annual inspection finding them in compliance with the provisions of 19 CSR 20-1.010. Inspections should be conducted by the local health department or by the Department of Health;

2. Those organizations arranging for provision of food services by agreement or contract with the second party shall assure that the provider has demonstrated compliance with this rule;

3. Programs providing meals shall implement a written plan to meet the dietary needs of the individuals being served, including:

A. Written menus developed and annually reviewed by a registered dietitian or qualified nutritionist who has at least a bachelor's degree from an accredited college with emphasis on foods and nutrition. The organization must maintain a copy of the dietitian's current registration or the qualified nutritionist's academic record.

B. Any changes or substitution in menus must be noted;

C. Menus for at least the past three (3) months shall be maintained;

D. The written dietary plan shall ensure that special diets for medical reasons are provided. Menu samples shall be maintained showing how special diets are developed or obtained;

E. Menus shall be responsive to cultural and religious beliefs of individuals;

4. Meals shall be served in a pleasant, relaxed dining area; and

5. Hand washing facilities including hot and cold water, soap and hand drying means shall be readily accessible.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10-7.090 Governing Authority and Program Administration

PURPOSE: This rule describes requirements for and responsibilities of the governing body in Alcohol and Drug Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.

(1) Governing Body. The organization has a designated governing body with legal authority and responsibility for the operation of the program(s).

(A) The organization is incorporated in the state of Missouri, maintains good standing in accordance with state law and regulation, and has bylaws identifying the structure of its governing body.

(B) Methods for selecting members of the governing body are delineated. A current list of members is maintained.

(C) Requirements of section (1) are not applicable to government entities, except that a government entity or public agency must have an administrative structure with identified lines of authority to ensure responsibility and accountability for the successful operation of its psychiatric and substance abuse services.

(2) Functions of the Governing Body. The governing body shall effectively implement the functions of—

(A) Providing fiscal planning and oversight;

(B) Ensuring organizational planning and quality improvement in service delivery;

(C) Establishing policies to guide administrative operations and service delivery;

(D) Ensuring responsiveness to the communities and individuals being served;

(E) Delegating operational management to an executive director and, as necessary, to program managers in order to effectively operate its services; and

(F) Designating contractual authority.

(3) Meetings. The governing body shall meet at least quarterly and maintain an accurate record of its meetings. Minutes of meetings must identify dates, those attending, discussion items, and actions taken.

(4) Policy and Procedure Manual. The organization maintains a current policy and procedure manual which accurately describes and guides the operation of its services, promotes compliance with applicable regulations, and is readily available to staff and the public upon request.

(5) Accountability. The organization establishes a formal, accountable relationship with any contractor or affiliate who provides direct service but who is not an employee of the organization.

(6) HIPAA Privacy Regulatory Compliance. The organization must comply with other applicable requirements as set forth in 9 CSR 10-5.220.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10-7.100 Fiscal Management

PURPOSE: This rule describes fiscal policies and procedures for Alcohol and Drug Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.

(1) Generally Accepted Accounting Principles. The organization has fiscal management policies, procedures and practices consistent with generally accepted accounting principles and, as applicable, state and federal law, regulation, or funding requirements.

(2) Monitoring and Reporting Financial Activity. The organization assigns responsibility for fiscal management to a designated staff member who has the skills, authority and support to fulfill these responsibilities.

(A) There is an annual budget of revenue by source and expenses by category that is approved in a timely manner by the governing body. Fiscal reports are prepared on at least a quarterly basis which compares the budget to actual experience. Fiscal reports are provided to and reviewed by the governing body and administrative staff who have ongoing responsibility for financial and program management.

(B) The organization utilizes financial activity measures to monitor and ensure its ability to pay current liabilities and to maintain adequate cash flows.

(C) There are adequate internal controls for safeguarding or avoiding misuse of assets.

(D) The organization has an annual audit by an independent, certified public accountant if required by funding sources or otherwise required by federal or state law or regulation.

(3) Fee Schedule. The organization has a current written fee schedule approved by the governing body and available to staff and individuals being served.

(4) Retention of Fiscal Records. Fiscal records shall be retained for at least five (5) years or until any litigation or adverse audit findings, or both, are resolved.

(5) Insurance Coverage. The organization shall have adequate insurance coverage to protect its physical and financial resources. Insurance coverage for all people, buildings and equipment shall be maintained and shall include fidelity bond, automobile liability, where applicable, and broad form comprehensive general liability for property damage, and bodily injury including wrongful death and incidental malpractice.

(6) Accountability for the Funds of Persons Served. If the organization is responsible for funds belonging to persons served, there shall be procedures that identify those funds and provide accountability for any expenditure of those funds. Such funds shall be expended or invested only with the informed consent and approval of the individuals or, if applicable, their legally appointed representatives. The individuals shall have access to the records of their funds. When benefits or personal allowance monies are received on behalf of individuals or when the organization acts as representative payee, such funds are segregated for each individual for accounting purposes and are used only for the purposes for which those funds were received.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10-7.110 Personnel

PURPOSE: This rule describes personnel policies and procedures for Alcohol and Drug Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.

(1) Policies and Procedures. The organization shall maintain personnel policies, procedures and practices in accordance with local, state and federal law and regulation. In addition to the requirements of this rule, the organization must also comply with 9 CSR 10-5.190 regarding criminal record background check and eligibility for employment.

(A) The policies and procedures shall include written job descriptions for each position and a current table of organization reflecting each position and, where applicable, the relationship to the larger organization of which the program or service is a part.

(B) Policies and procedures shall be consistently and fairly applied in the recruitment, selection, development and termination of staff.

(2) Qualified and Trained Staff. Qualified staff shall be available in sufficient numbers to ensure effective service delivery.

(A) The organization shall ensure that staff possesses the training, experience and credentials to effectively perform their assigned services and duties.

(B) A background screening shall be conducted in accordance with 9 CSR 10-5.190.

(C) Qualifications and credentials of staff shall be verified prior to employment, with primary source verification completed within ninety (90) days.

(D) There is clinical supervision of direct service staff that ensures adequate supervisory oversight and guidance, particularly for those staff that may lack credentials for independent practice in Missouri.

(E) Training and continuing education opportunities are available to all direct service staff, in accordance with their job duties and any licensing or credentialing requirements.

1. All staff who provide services or are responsible for the supervision of persons served shall participate in at least thirty-six (36) clock hours of relevant training during a two (2)-year period.

2. Training shall assist staff in meeting the needs of persons served, including persons with co-occurring disorders.

3. The organization shall maintain a record of participation in training and staff development activities.

(F) When services and supervision are provided twenty-four (24) hours per day, the organization maintains staff on duty, awake and fully dressed at all times. A schedule or log is maintained which accurately documents staff coverage.

(3) Ethical Standards of Behavior. Staff shall adhere to ethical standards of behavior in their relationships with individuals being served.

(A) Staff shall maintain an objective, professional relationship with individuals being served at all times.

(B) Staff shall not enter dual or conflicting relationships with individuals being served which might affect professional judgment or increase the risk of exploitation.

(C) The organization shall establish policies and procedures regarding staff relationships with both individuals currently being served and individuals previously served.

(4) Volunteers. If the agency uses volunteers, it shall establish and consistently implement policies and procedures to guide the roles and activities of volunteers in an organized and productive manner. The agency shall ensure that volunteers have a background screening in accordance with 9 CSR 10-5.190 and adequate supervision.

(5) Practicum/Intern Students. A practicum/intern student if used in a Department of Mental Health (DMH) program must be enrolled and participating in an accredited college/university in a field of study including but not limited to social work, psychology, sociology or nursing.

(A) The student and agency must have a written plan documenting the following:

1. Name of individual, educational institution, and degree program;

2. Brief description of the status of the individual with respect to degree completion, including: semester/hours remaining, projected completion date, and time period of the practicum or internship;

3. A description of the specific job status of the individual with respect to agency program and client population;

4. A specific plan for supervision of the student, including name and title of the direct supervisor. The plan must detail the frequency and duration of the supervision activities including the scope of case/record reviews, the location of the supervisor with respect to the service delivery locations, and emergency backup supervision arrangements; and

5. A list of the specific Purchase of Service (POS) services the agency has approved for the student to deliver. Students may not deliver Medicaid-eligible services unless they meet the provider eligibility requirements through prior experience and education.

(B) The student must have a letter from their academic advisor attesting to their qualifications and eligibility for the proposed practicum.

(C) The student must be under the close supervision of the direct clinical supervising professional of the agency. The person providing the supervision must be qualified to provide the services they are supervising.

1. For providing counseling services a student must be in a master's program or above, and be approved for the practicum by the college/university.

2. To provide case management and community support work, and other support services, a student must be in the final year of a bachelor's program or above.

3. A student may be assigned a limited caseload based on background and prior experience.

(D) A student must be background screened, oriented and trained as consistent with the agency's policies for new employees.

(E) Service delivery by the student must be documented according to department standards and policy.

1. All documentation of billable services must be reviewed and countersigned by an individual who meets the division criteria for a qualified mental health professional or supervisor of counselors, a community support worker, or case manager, as appropriate.

2. Services shall be billed using appropriate existing service codes and reimbursed at the established contract rate for the anticipated degree, unless a distinct student rate has been established for the service.

(F) For Division of Alcohol and Drug Abuse funded contracts, the services are limited to individual counseling, group counseling, group education and community support work.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Aug. 28, 2002, effective April 30, 2003.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10-7.120 Physical Plant and Safety

PURPOSE: This rule describes requirements for the physical facilities and safety in Alcohol and Drug Treatment Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.

(1) Applicable Requirements for All Facilities and for Residential Facilities. This rule is organized as follows:

(A) Sections (2) through (9) apply to all facilities and program sites subject to certification by the department; and

(B) Section (10) applies to residential facilities only.

(2) Safety Inspections. Each individual shall be served in a safe facility.

(A) All buildings used for programmatic activities or residential services by the organization shall meet applicable state and local fire safety and health requirements. At the time of the initial application and after that, whenever renovations are made, the organization shall submit to the department verification that the facility complies with requirements for the building, electrical system, plumbing, heating system and, where applicable, water supply.

(B) The organization shall maintain documentation of all inspections and correction of all cited deficiencies to assure compliance with applicable state and local fire safety and health requirements. These inspection and documentation requirements may be waived for a nonresidential service site that operates less than three (3) hours per day, two (2) days per week.

(C) A currently certified organization that relocates any program into new physical facilities shall have the new facilities comply with this rule in order to maintain certification. All additions or expansions to existing physical facilities must meet the requirements of this rule.

(3) Physical Access. Individuals are able to readily access the organization's services. The organization shall demonstrate an ability to remove architectural and other barriers that may confront individuals otherwise eligible for services.

(4) Adequate Space and Furnishings. Individuals are served in a setting with adequate space, equipment and furnishings for all program activities and for maintaining privacy and confidentiality.

(A) In keeping with the specific purpose of the service, the organization shall make available—

1. A reception/waiting area;
2. Private areas for individual counseling and family therapy;
3. A private area(s) for group counseling, education and other group services;
4. An area(s) for indoor social and recreational activities in residential settings and in nonresidential settings where individuals are scheduled for more than four (4) hours per day; and
5. Separate toilet facilities for each sex, except where reasonable evidence is shown to the department that this is not necessary.

(B) The organization shall have appropriate furnishings which are clean and in good repair.

(C) The use of appliances such as television, radio and stereo equipment shall not interfere with the therapeutic program.

(5) Clean and Comfortable Setting. Individuals are served in settings that are clean and comfortable, in good repair, and in safe operating order. The organization shall—

(A) Provide adequate and comfortable lighting;

(B) Maintain a comfortable room temperature between sixty-eight degrees Fahrenheit (68°F) and eighty degrees Fahrenheit (80°F);

(C) Provide screens on outside doors and windows if they are to be kept open;

(D) Provide effective pest control measures;

(E) Store refuse in covered containers so as not to create a nuisance or health hazard;

(F) Maintain the facility free of undesirable odors;

(G) Provide stocked, readily accessible first-aid supplies; and

(H) Take measures to prevent, detect and control infections among individuals and personnel, and have protocols for proper treatment.

(6) Off-Site Functions. If the organization offers certain services at locations in the community other than at its facilities, the organization shall take usual and reasonable precautions to preserve the safety of individuals participating in these off-site locations.

(7) Emergency Preparedness. The organization shall have an emergency preparedness plan.

(A) The plan shall address medical emergencies and natural disasters.

(B) Evacuation routes shall be posted, or the organization shall maintain a written evacuation plan.

(C) Staff shall demonstrate knowledge and ability to affect the emergency preparedness plan and, where applicable, the evacuation plan.

(D) Emergency numbers for the fire department, police and poison control shall be posted and readily visible near the telephone.

(8) Fire Safety. The organization shall maintain fire safety equipment and practices to protect all occupants.

(A) Portable ABC type fire extinguishers shall be located on each floor used by individuals being served so that no one will have to travel more than one hundred feet (100') from any point to reach the nearest extinguisher. Additional fire extinguishers shall be provided, where applicable, for the kitchen, laundry and furnace areas.

(B) Fire extinguishers shall be clearly visible and maintained with a charge.

(C) There shall be at least two (2) means of exit on each floor used by individuals being served, which are independent of and remote from one another.

1. Outside fire escape stairs may constitute one (1) means of exit in existing buildings. Fire escape ladders shall not constitute one (1) of the required means of exit.

2. The means of exit shall be free of any item that would obstruct the exit route.

3. Outside stairways shall be substantially constructed to support people during evacuation. Newly constructed fire exits shall meet requirements of the National Fire Protection Association (NFPA) *Life Safety Code.*

4. Outside stairways shall be reasonably protected against blockage by a fire. This may be accomplished by physical separation, distance, arrangement of the stairs, and protection of openings exposing the stairs or other means acceptable to the fire authority.

5. Outside stairways at facilities with three (3) or more stories shall be constructed of noncombustible material, such as iron or steel.

(D) Unless otherwise determined by the fire inspector based on a facility's overall size and use, the requirement of two (2) or more means of exit on each floor shall be waived for those sites that meet each of the following conditions:

1. Do not offer overnight sleeping accommodations;

2. Do not cook meals on a regular basis; and

3. Do not provide services on-site to twenty (20) or more individuals at a given time as a usual and customary pattern of service delivery.

(E) The requirement for two (2) means of exit from the second floor shall be waived for a residential facility if it serves no more than four (4) individuals and each of those individuals—

1. Is able to hear and see;

2. Is able to recognize a fire alarm as a sign of danger;

3. Is ambulatory and able to evacuate the home without assistance in an emergency; and

4. Has staff available in the event that assistance is needed.

(F) Ceiling height shall be at least seven feet ten inches (7'10") in all rooms used by persons served except as follows:

1. Hallways and bathrooms shall have a ceiling height of at least seven feet six inches (7'6"); and

2. Existing facilities inspected and approved by the department during a certification site survey prior to the effective date of this rule may request an exception from this ceiling height requirement.

(G) Combustible supplies and equipment, such as oil base paint, paint thinner and gasoline, shall be separated from other parts of the building in accordance with stipulations of the fire authority.

(H) The use of wood, gas or electric fireplaces shall not be permitted unless they are installed in compliance with the NFPA codes and the facility has prior approval of the department.

(I) The *Life Safety Code* of the NFPA shall prevail in the interpretation of these fire safety standards.

(J) Fire protection equipment required shall be installed in accordance with NFPA codes.

(K) The facility shall be smoke-free, unless otherwise stipulated in program specific rules.

(9) Safe Transportation. Where applicable, the organization shall implement measures to ensure safe transportation for persons served.

(A) Agency owned vehicles which are used by the organization to transport persons served shall have—

1. Regular inspection and maintenance as legally required; and

2. Adequate first-aid supplies and fire suppression equipment which are secured in any van, bus or other vehicle used to transport more than four (4) clients. Staff that operates such a vehicle shall have training in emergency procedures and the handling of accidents and road emergencies.

(B) All staff that transport persons served shall be properly licensed with driving records acceptable to the agency.

(C) There shall be a current certificate of insurance for agency owned vehicles in accordance with the organization's requirements.

(10) Residential Facilities. In addition to the requirements under sections (1) through (8) of this rule, residential facilities shall also meet the following additional requirements:

(A) Residential facilities shall provide—

1. At least one (1) toilet, one (1) lavatory with a mirror and one (1) tub or shower for each six (6) individuals provided overnight sleeping accommodations;

2. Bathroom(s) in close proximity to the bedroom area(s);

3. Privacy for personal hygiene, including stalls or other means of separation acceptable to the department when a bathroom has multiple toilets, urinals or showers;

4. Laundry area or service;

5. Adequate supply of hot water;

6. Lockable storage space for the use of each individual being served;

7. Furniture and furnishings suitable to the purpose of the facility and individuals;

8. Books, newspapers, magazines, educational materials, table games and recreational equipment, in accordance with the interests and needs of individuals;

9. An area(s) for dining;

10. Windows which afford visual access to out-of-doors and, if accessible from the outside, are lockable; and

11. Availability of outdoor activities;

(B) Bedrooms in residential facilities shall:

1. Have no more than four (4) individuals per bedroom;

2. Have separate areas for males and females subject to the department's approval;

3. Provide at least sixty (60) square feet of floor space per individual in multiple sleeping rooms and eighty (80) square feet per individual in single sleeping rooms. Additional space shall be required, if necessary to accommodate special medical or other equipment

needed by individuals. In the computation of space in a bedroom with a sloped ceiling, floor space shall be limited to that proportion of the room having a ceiling height as required elsewhere in this rule. Square feet of contiguous floor space for each individual shall be computed by using the inside dimensions of the room in which the person's bed is physically located less that square footage of floor space required by any other individuals and less any walled, closed space within the room;

4. Have a separate bed with adequate headroom for each individual. Cots and convertibles shall not be used. If bunk beds are used they shall be sturdy, have braces to prevent rolling from the top bunk, and be convertible to two (2) floor beds if an individual does not desire a bunk bed;

5. Provide storage space for the belongings of each individual, including space for hanging clothes;

6. Encourage the display of personal belongings in accordance with treatment goals;

7. Provide a set of linens, a bedspread, a pillow and blankets as needed;

8. Have at least one (1) window which operates as designed;

9. Have a floor level which is no more than three feet (3') below the outside grade on the window side of the room; and

10. Not be housed in a mobile home, unless otherwise stipulated in program specific rules;

(C) Activity space in residential facilities shall:

1. Total eighty (80) square feet for each individual, except that additional space shall be required, if necessary to accommodate special medical or other equipment needed by individuals. Activity space includes the living room, dining room, counseling areas, recreational and other activity areas. Activity space does not include the laundry area, hallways, bedrooms, bathrooms or supply storage area; and

2. Not be used for other purposes if it reduces the quality of services;

(D) In all residential facilities, fire safety precautions shall include—

1. An adequate fire detection and notification system which detects smoke, fumes and/or heat, and which sounds an alarm which can be heard throughout the facility above the noise of normal activities, radios and televisions;

2. Bedroom walls and doors that are smoke resistant. Transfer grilles are prohibited;

3. A range hood and extinguishing system for a commercial stove or deep fryer. The extinguishing system shall include automatic cutoff of fuel supply and exhaust system in case of fire; and

4. An annual inspection in accordance with the *Life Safety Code* of the National Fire Protection Association (NFPA);

(E) Residential facilities with more than four (4) individuals shall provide—

1. Smoke detectors powered by the electrical system with an emergency power backup. These detectors shall activate the alarm system. They shall be installed on all floors, including basements. Detectors shall be installed in living rooms or lounges. Heat detectors may be used in utility rooms, furnace rooms and unoccupied basements and attics;

2. Smoke detectors in each sleeping room. Those detectors may be battery operated and are not required to initiate the building fire alarm system;

3. At least one (1) manual fire alarm station per floor arranged to continuously sound the smoke detection alarm system or other continuously sounding manual alarms acceptable to the authority having jurisdiction. The requirement of at least one (1) manual fire alarm station per floor may be waived where there is an alarm station at a central control point under continuous supervision of a responsible employee;

4. An alarm which is audible in all areas. There shall be an annual inspection of the alarm system by a competent authority;

5. A primary means of egress which is a protected vertical opening. Protected vertical openings shall have doors that are self-closing or automatic closing upon detection of smoke. Doors shall be at least one and one-half inches (1 1/2") in existing facilities and one and three-fourths inches (1 3/4") in new construction, of solid bonded wood core construction or other construction of equal or greater fire resistance;

6. Emergency lighting of the means of egress; and

7. Readily visible, approved exit signs, except at doors leading directly from rooms to an exit corridor and except at doors leading obviously to the outside from the entrance floor. Every exit sign shall be visible in both the normal and emergency lighting mode;

(F) In residential facilities with more than twenty (20) individuals—

1. Neither of the required exits shall be through a kitchen;

2. No floor below the level of exit discharge, used only for storage, heating equipment or purposes other than residential occupancy shall have unprotected openings to floors used for residential purposes;

3. Doors between bedrooms and corridors shall be one and one-half inches (1 1/2") in existing facilities, and one and three-fourths inches (1 3/4") in new construction, solid bonded wood core construction or other construction of equal or greater fire resistance;

4. Unprotected openings shall be prohibited in interior corridors serving as exit access from bedrooms; and

5. A primary means of egress which is an enclosed vertical opening. This vertical opening shall be enclosed with twenty (20)-minute fire barriers and doors that are self-closing or automatic closing upon detection of smoke.

(G) In detoxification programs—

1. The means of exit shall not involve windows;

2. The interior shall be fully sheathed in plaster or gypsum board, unless the group can evacuate in eight (8) minutes or less; and

3. Bedroom doors shall be one and one-half inches (1 1/2") in existing facilities, and one and three-fourths inches (1 3/4") in new construction, solid bonded wood core construction or other construction of equal or greater fire resistance, unless the group can evacuate in eight (8) minutes or less.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10-7.130 Procedures to Obtain Certification

PURPOSE: This rule describes procedures to obtain certification as Alcohol and Drug Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.

(1) Under sections 630.655, 630.010, and 376.779.3 and 4, RSMo, the department is mandated to develop certification standards and to certify an organization's level of service, treatment or rehabilitation as necessary for the organization to operate, receive funds from the department, or participate in a service network authorized by the department and eligible for Medicaid reimbursement. However, certification in itself does not constitute an assurance or guarantee that the department will fund designated services or programs.

(A) A key goal of certification is to enhance the quality of care and services with a focus on the needs and outcomes of persons served.

(B) The primary function of the certification process is assessment of an organization's compliance with standards of care. A further function is to identify and encourage developmental steps toward improved program operations, client satisfaction and positive outcomes.

(2) An organization may request certification by completing an application form, as required by the department for this purpose, and submitting the application form, and other documentation, as may be specified, to the Department of Mental Health, PO Box 687, Jefferson City, MO 65102.

(A) The organization must submit a current written description of those programs and services for which it is seeking certification by the department.

(B) A new applicant shall not use a name which implies a relationship with another organization, government agency or judicial system when a formal organizational relationship does not exist.

(C) Certification fees are not required, except for the Substance Abuse Traffic Offender Program (SATOP). A nonrefundable fee of one hundred twenty-five dollars ($125) is required upon initial application. Renewal fees are as follows:

1. A fee of one hundred twenty-five dollars ($125) is required if the aggregate number of individuals being served in the SATOP program(s) during the preceding state fiscal year was less than two hundred fifty (250) individuals;

2. A fee of two hundred fifty dollars ($250) is required if the aggregate number of individuals being served in the SATOP program(s) during the preceding state fiscal year was at least two hundred fifty (250) but no more than four hundred ninety-nine (499); or

3. A fee of five hundred dollars ($500) is required if the aggregate number of individuals being served in the SATOP program(s) during the preceding state fiscal year was at least five hundred (500).

(D) The fee schedule may be adjusted annually by the department.

(E) The department will review a completed application within thirty (30) calendar days of receipt to determine whether the applicant organization would be appropriate for certification. The department will notify the organization of its determination. Where applicable, an organization may qualify for expedited certification in accordance with subsections (3) (B) and (C) of this rule by submitting to the department required documentation and verification of its accreditation or other deemed status.

(F) An organization that wishes to apply for recertification shall submit its application forms to the department at least sixty (60) days before expiration of its existing certificate.

(G) An applicant can withdraw its application at any time during the certification process, unless otherwise required by law.

(3) The department shall conduct a site survey at an organization to assure compliance with standards of care and other requirements. The department shall determine which standards and requirements are applicable, based on the application submitted and the on-site survey.

(A) The department shall conduct a comprehensive site survey for the purpose of determining compliance with core rules and program/service rules, except as stipulated in subsections (3) (B) and (C).

(B) The department shall conduct an expedited site survey when an organization has attained full accreditation under standards for behavioral healthcare from the Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or the Council on Accreditation of Services to Families and Children (COA).

1. The survey shall monitor compliance with applicable program/service rules promulgated by the department.

2. The survey shall not monitor core rules, except for those requirements designated by the department as essential to—

A. Providing and documenting services funded by the department or provided through a service network authorized by the department;

B. Assuring the qualifications and credentials of staff members providing these services;

C. Protecting the rights of individuals being served, including mechanisms for grievances and investigations; and

D. Funding, contractual, or other legal relationship between the organization and the department.

(C) The department shall grant a certificate, upon receipt of a completed application, to an organization which has attained full accreditation under standards for behavioral healthcare from CARF, JCAHO or COA; does not provide methadone treatment; does not receive funding from the department; and does not participate in a service network authorized by the department.

1. The organization must submit a copy of the most recent accreditation survey report and verification of the accreditation time period and dates.

2. The department shall review its categories of programs and services available for certification and shall determine those which are applicable to the organization. The department, at its option, may visit the organization's program site(s) solely for the purpose of clarifying information contained in the organization's application and its description of programs and services, and/or determining those programs and services eligible for certification by the department.

(4) The department shall provide advance notice and scheduling of routine, planned site surveys.

(A) The department shall notify the applicant regarding survey date(s), procedures and a copy of any survey instrument that may be used. Survey procedures may include, but are not limited to, interviews with organization staff, individuals being served and other interested parties; tour and inspection of treatment sites; review of organization administrative records necessary to verify compliance with requirements; review of personnel records and service documentation; observation of program activities; and review of data regarding practice patterns and outcome measures, as available.

(B) The applicant agrees, by act of submitting an application, to allow and assist department representatives in fully and freely conducting these survey procedures and to provide department representatives reasonable and immediate access to premises, individuals, and requested information.

(C) An organization must engage in the certification process in good faith. The organization must provide information and documentation that is accurate, and complete. Failure to participate in good faith, including falsification or fabrication of any information used to determine compliance with requirements, may be grounds to deny issuance of or to revoke certification.

(D) The surveyor(s) shall hold entrance and exit conferences with the organization to discuss survey arrangements and survey findings, respectively. A surveyor shall immediately cite any deficiency which could result in actual jeopardy to the safety, health or welfare of persons served. The surveyor shall not leave the program until an acceptable plan of correction is presented which assures the surveyor that there is no further risk of jeopardy to persons served.

(E) Within thirty (30) calendar days after the exit conference, the department shall provide a written survey report to the organization's director and governing authority.

1. The report shall note any deficiencies identified during the survey for which there was not prompt, remedial action.

2. The organization shall make the report available to the staff and to the public upon request.

3. Where applicable, the department shall send a notice of deficiency by certified mail, return receipt requested.

(F) Within thirty (30) calendar days of the date that a notice of deficiency is presented by certified mail to the organization, it shall submit to the department a plan of correction.

1. The plan must address each deficiency, specifying the method of correction and the date the correction shall be completed.

2. Within fifteen (15) calendar days after receiving the plan of correction, the department shall notify the organization of its decision to approve, disapprove, or require revisions of the proposed plan.

3. In the event that the organization has not submitted a plan of correction acceptable to the department within ninety (90) days of the original date that written notice of deficiencies was presented by certified mail to the organization, it shall be subject to expiration of certification.

(5) The department may grant certification on a temporary, provisional, conditional, or compliance status. In determining certification status, the department shall consider patterns and trends of performance identified during the site survey.

(A) Temporary status shall be granted to an organization if the survey process has not been completed prior to the expiration of an existing certificate and the applicant is not at fault for failure or delay in completing the survey process.

(B) Provisional status for a period of one hundred eighty (180) calendar days shall be granted to a new organization or program based on a site review which finds the program in compliance with requirements related to policy and procedure, facility, personnel, and staffing patterns sufficient to begin providing services.

1. In the department's initial determination and granting of provisional certification, the organization shall not be expected to fully comply with those standards which reflect ongoing program activities.

2. Within one hundred eighty (180) calendar days of granting provisional certification, the department shall conduct a comprehensive or expedited site survey and shall make a further determination of the organization's certification status.

(C) Conditional status shall be granted to an organization which, upon a site survey by the department, is found to have numerous or significant deficiencies with standards that may affect quality of care to individuals but there is reasonable expectation that the organization can achieve compliance within a stipulated time period.

1. The period of conditional status shall not exceed one hundred eighty (180)-calendar days. The department may directly monitor progress, may require the organization to submit progress reports, or both.

2. The department shall conduct a further site survey within the one hundred eighty (180)-day period and make a further determination of the organization's compliance with standards.

(D) Compliance status for a period of one (1) year shall be awarded to an organization which, upon a site survey by the department, is found to meet all standards relating to quality of care and the safety, health and welfare of persons served. A two (2)-year time period of certification may be granted when an organization achieves compliance for three (3) consecutive surveys with no deficiencies related to quality of care and the safety, health and welfare of persons served.

(E) For organizations that have attained full accreditation under standards for behavioral healthcare from CARF, JCAHO, and COA, and that receive an expedited site survey from the department, compliance status from the department shall be for a period of time equal to the length of the accreditation received from the accrediting entity.

(6) The department may investigate any written complaint regarding the operation of a certified program or service.

(7) The department may conduct a scheduled or unscheduled site survey of an organization at any time to monitor ongoing compliance with these rules. If any survey finds conditions that are not in compliance with applicable certification standards, the department may require corrective action steps and may change the organization's certification status consistent with procedures set out in this rule.

(8) The department shall certify only the organization named in the application, and the organization may not transfer certification without the written approval of the department.

(A) A certificate is the property of the department and is valid only as long as the organization meets standards of care and other requirements.

(B) The organization shall maintain the certificate issued by the department in a readily available location.

(C) Within seven (7) calendar days of the time a certified organization is sold, leased, discontinued, moved to a new location, has a change in its accreditation status, appoints a new director, or changes programs or services offered, the organization shall provide written notice to the department of any such change.

(D) A certified organization that establishes a new program or type of program shall operate that program in accordance with applicable standards. A provisional review, expedited site survey or comprehensive site survey shall be conducted, as determined by the department.

(9) The department may deny issuance of and may revoke certification based on a determination that—

(A) The nature of the deficiencies results in substantial probability of or actual jeopardy to individuals being served;

(B) Serious or repeated incidents of abuse or neglect of individuals being served or violations of rights have occurred;

(C) Fraudulent fiscal practices have transpired or significant and repeated errors in billings to the department have occurred;

(D) Failure to participate in the certification process in good faith, including falsification or fabrication of any information used to determine compliance with requirements;

(E) The nature and extent of deficiencies results in the failure to conform to the basic principles and requirements of the program or service being offered; or

(F) Compliance with standards has not been attained by an organization upon expiration of conditional certification.

(10) The department, at its discretion, may—

(A) Place a monitor at a program if there is substantial probability of or actual jeopardy to the safety, health or welfare of individuals being served.

1. The cost of the monitor shall be charged to the organization at a rate which recoups all reasonable expenses incurred by the department.

2. The department shall remove the monitor when a determination is made that the safety, health and welfare of individuals being served is no longer at risk.

(B) Take other action to ensure and protect the safety, health or welfare of individuals being served.

(11) An organization which has had certification denied or revoked may appeal to the director of the department within thirty (30) calendar days following notice of the denial or revocation being presented by certified mail to the organization. The director of the department shall conduct a hearing under procedures set out in Chapter 536, RSMo and issue findings of fact, conclusions of law and a decision which shall be final.

(12) The department shall have authority to impose administrative sanctions.

(A) The department may suspend the certification process pending completion of an investigation when an organization that has applied for certification or the staff of that organization is under investigation for fraud, financial abuse, abuse of persons served, or improper clinical practices.

(B) The department may administratively sanction a certified organization that has been found to have committed fraud, financial abuse, and abuse of persons served, or improper clinical practices or that had reason to know its staff was engaged in such practices.

(C) Administrative sanctions include, but are not limited to, suspension of certification, clinical utilization review requirements, suspension of new admissions, denial or revocation of certification, or other actions as determined by the department.

(D) The department shall have the authority to refuse to accept for a period of up to twenty-four (24) months an application for certification from an organization that has had certification denied or revoked or that has been found to have committed fraud, financial abuse or improper clinical practices or whose staff and clinicians were engaged in improper practices.

(E) An organization may appeal these sanctions pursuant to section (11).

(13) An organization may request the department's exceptions committee to waive a requirement for certification if the head of the organization provides evidence that a waiver is in the best interests of the individuals it serves.

(A) A request for a waiver shall be in writing and shall include justification for the request.

(B) The request shall be submitted to Exceptions Committee, Department of Mental Health, P.O. Box 687, Jefferson City, MO 65102.

(C) The exceptions committee shall hold meetings in accordance with Chapter 610, RSMo and shall respond with a written decision within forty-five (45) calendar days of receiving a request.

(D) The exceptions committee may issue a waiver on a time-limited or other basis.

(E) If a waiver request is denied, the exceptions committee shall give the organization forty-five (45) calendar days to fully comply with the standard, unless a different time period is specified by the committee.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Sept. 25, 2002, effective April 30, 2003.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

9 CSR 10-7.140 Definitions

PURPOSE: This rule defines terms used in the certification of psychiatric and substance abuse programs.

(1) The definitions included in this rule shall apply to:

(A) 9 CSR 10-7 Core Rules for Psychiatric and Substance Abuse Programs;

(B) 9 CSR 30-3 Certification Standards for Alcohol and Drug Abuse; and

(C) 9 CSR 30-4 Certification Standards for Mental Health Programs.

(2) Unless the context clearly indicates otherwise, the following terms shall mean:

(A) Abstinence, the non-use of alcohol and other drugs;

(B) Admission, entry into the treatment and rehabilitation process after an organization has determined an individual meets eligibility criteria for receiving its services;

(C) Adolescent, a person between the ages of twelve through seventeen (12–17) years inclusive;

(D) Agency, this term may be used interchangeably with organization. See the definition of organization;

(E) Alcohol or drug-related traffic offense, an offense of driving while intoxicated, driving with excessive blood alcohol content, or driving under the influence of alcohol or drugs in violation of state law;

(F) Alcohol or drug treatment and rehabilitation program, a program certified by the Department of Mental Health as providing treatment and rehabilitation of substance abuse in accordance with service and program requirements under 9 CSR 30-3.100 through 9 CSR 30-3.199;

(G) Applicant, an organization seeking certification from the department under 9 CSR 30;

(H) Assessment, systematically collecting information regarding the individual's current situation, symptoms, status and background, and developing a treatment plan that identifies appropriate service delivery;

(I) Associate substance abuse counselor, a trainee that must meet requirements for registration, supervision, and professional development as set forth by either—

1. The Missouri Substance Abuse Counselors Certification Board, Inc.; or

2. The appropriate board of professional registration within the Department of Economic Development for licensure as a psychologist, professional counselor, or social worker;

(J) Certification, determination and recognition by the Department of Mental Health that an organization complies with applicable rules and standards of care under 9 CSR;

(K) Client, this term may be used interchangeably with individual. See the definition of individual;

(L) Clinical utilization review, a process of service authorization and/or review established by the department and conducted by credentialed staff in order to promote the delivery of services that are necessary, appropriate, likely to benefit the individual, and provided in accordance with admission criteria and service definitions;

(M) Compulsive gambling, the chronic and progressive preoccupation with gambling and the urge to gamble. This term may be used interchangeably with pathological gambling;

(N) Co-occurring disorders, presence of both substance and psychiatric disorders which impede the individual's functioning or ability to manage daily activities, consistent with diagnostic criteria established in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association;

(O) Corporal punishment, purposeful infliction of physical pain upon an individual for punitive or disciplinary reasons;

(P) Crisis, an event or time period for an individual characterized by substantial increase in symptoms, legal or medical problems, and/or loss of housing or employment or personal supports;

(Q) Day, a calendar day unless specifically stated otherwise;

(R) Deficiency, a condition, event or omission that does not comply with a certification rule;

(S) Department, the Department of Mental Health;

(T) Director, the Department of Mental Health director or designee;

(U) Discharge, the time when an individual's active involvement with the program concludes in accordance with treatment plan goals, any applicable utilization criteria, and/or program rules;

(V) Discharge planning, an activity to assist an individual's further participation in services and supports in order to promote continued recovery upon completion of a program or level of care;

(W) Facility, physical plant or site used to provide services;

(X) Family/family members, persons who comprise a household or are otherwise related by marriage or ancestry and are being affected by the psychiatric or substance abuse problems of another member of the household or family;

(Y) Improper clinical practices, performance or behavior which constitutes a repeated pattern of negligence or which constitutes a continuing pattern of violations of laws, rules, or regulations;

(Z) Individual, a person/consumer/-client receiving services from a program certified under 9 CSR 30;

(AA) Least restrictive environment and set of services, a reasonably available setting or program where care, treatment, and rehabilitation is particularly suited to the type and intensity of services necessary to implement a person's treatment plan and to assist the person in maximizing functioning and participating as freely as feasible in normal living activities, giving due consideration to the safety of the individual, other persons in the program, and the general public;

(BB) Licensed independent practitioner, a person who is licensed by the state of Missouri to independently perform specified practices in the health care field;

(CC) Medication, a drug prescribed by a physician or other legally authorized professional for the purpose of treating a medical condition;

(DD) Medication (self-administration under staff observation), actions wherein an individual takes prescribed medication, including selection of the appropriate dose from a properly labeled container. The individual has primary responsibility for taking medication as prescribed, with the staff role to ensure client access to their personal medication in a timely manner and to observe clients as they select and ingest medication;

(EE) Mental health, a broad term referring to disorders related to substance abuse, mental illness and/or developmental disability;

(FF) Mental illness, impairment or disorder that impedes an individual's functioning or ability to manage daily activities and otherwise meets eligibility criteria established by the Division of Comprehensive Psychiatric Services;

(GG) Neglect (Class I), in accordance with 9 CSR 10-5.200;

(HH) Neglect (Class II), in accordance with 9 CSR 10-5.200;

(II) Nonresidential, service delivery by an organization that does not include overnight sleeping accommodations as a component of providing twenty-four (24) hour per day supervision and structure;

(JJ) Organization, an agency that is incorporated and in good standing under the requirements of the Office of the Secretary of State of Missouri and that provides care, treatment or rehabilitation services to persons with mental illness or substance abuse;

(KK) Outcome, a specific measurable result of services provided to an individual or identified target population;

(LL) Peer support, mutual assistance in promoting recovery offered by other persons experiencing similar psychiatric or substance abuse challenges;

(MM) Performance indicator, data used to measure the extent to which a treatment principle, expected outcome, or desired process has been achieved;

(NN) Physical abuse, in accordance with 9 CSR 10-5.200;

(OO) Primary diagnosis, a diagnosis of a mental illness, disability, or substance abuse disorder that is not due to a co-existing illness. A person with a primary diagnosis would still meet full criteria for that diagnosis in the absence of any co-existing disorder. A person may have several primary diagnoses, and a primary diagnosis is not necessarily the diagnosis causing the most severe impairment.

(PP) Program, an array of services designed to achieve specific goals for an identified target population in accordance with designated procedures and practices;

(QQ) Qualified mental health professional—any of the following:

1. A physician licensed under Missouri law to practice medicine or osteopathy and with training in mental health services or one (1) year of experience, under supervision, in treating problems related to mental illness or specialized training;

2. A psychiatrist, a physician licensed under Missouri law who has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association or other training program identified as equivalent by the department;

3. A psychologist licensed under Missouri law to practice psychology with specialized training in mental health services;

4. A professional counselor licensed under Missouri law to practice counseling and with specialized training in mental health services;

5. A clinical social worker licensed under Missouri law with a master's degree in social work from an accredited program and with specialized training in mental health services;

6. A psychiatric nurse, a registered professional nurse licensed under Chapter 335, RSMo with at least two (2) years of experience in a psychiatric setting or a master's degree in psychiatric nursing;

7. An individual possessing a master's or doctorate degree in counseling and guidance, rehabilitation counseling and guidance, rehabilitation counseling, vocational counseling, psychology, pastoral counseling or family therapy or related field who has successfully completed a practicum or

has one (1) year of experience under the supervision of a mental health professional;

8. An occupational therapist certified by the American Occupational Therapy Certification Board, registered in Missouri, has a bachelor's degree and has completed a practicum in a psychiatric setting or has one (1) year of experience in a psychiatric setting, or has a master's degree and has completed either a practicum in a psychiatric setting or has one (1) year of experience in a psychiatric setting;

9. An advanced practice nurse— as set forth in section 335.011, RSMo, a nurse who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the Board of Nursing; and

10. A psychiatric pharmacist as defined in 9 CSR 30-4.030;

(RR) Qualified substance abuse professional, a person who demonstrates substantial knowledge and skill regarding substance abuse by being either—

1. A counselor, psychologist, social worker or physician licensed in Missouri who has at least one (1) year of full-time experience in the treatment or rehabilitation of substance abuse;

2. A graduate of an accredited college or university with a master's degree in social work, counseling, psychology, psychiatric nursing or closely related field who has at least two (2) years of full-time experience in the treatment or rehabilitation of substance abuse;

3. A graduate of an accredited college or university with a bachelor's degree in social work, counseling, psychology or closely related field who has at least three (3) years of full-time experience in the treatment or rehabilitation of substance abuse; or

4. An alcohol, drug or substance abuse counselor certified by the Missouri Substance Abuse Counselors Certification Board, Inc.;

(SS) Quality improvement, an approach to the continuous study and improvement of the service delivery process and outcomes in order to effectively meet the needs of persons served;

(TT) Recovery, continuing steps toward a positive state of health that includes stabilized symptoms of mental illness, substance abuse or both, meaningful and productive relationships and roles within the community, and a sense of personal well-being, independence, choice and responsibility to the fullest extent possible;

(UU) Rehabilitation, a process of restoring a person's ability to attain or maintain normal or optimum health or constructive activity by providing services and supports;

(VV) Relapse, recurrence of substance abuse in an individual who has previously achieved and maintained abstinence for a significant period of time beyond detoxification;

(WW) Relapse prevention, assisting individuals to identify and anticipate high risk situations for substance use, develop action steps to avoid or manage high risk situations, and maintain recovery;

(XX) Research, in accordance with 9 CSR 60-1.010 this term is defined as experimentation or intervention with or on individuals, including behavioral or psychological research, biomedical research, and pharmacological research. Excluded are those instances where the manipulation or application is intended solely and explicitly for individual treatment of a condition, falls within the prerogative of accepted practice and is subject to appropriate quality assurance review. Also excluded are activities limited to program evaluation conducted by staff members as a regular part of their jobs, the collection or analysis of management information system data, archival research or the use of departmental statistics;

(YY) Residential, service delivery by an organization that includes overnight sleeping accommodations as a component of providing twenty-four (24) hour per day supervision and structure;

(ZZ) Restraint, restricting an individual's ability to move by physical, chemical or mechanical methods in order to maintain safety when all other less restrictive interventions are inadequate;

(AAA) Restraint (chemical), medication not prescribed to treat an individual's medical condition and administered with the primary intent of restraining an individual who presents a likelihood of physical injury to self or others;

(BBB) Restraint (mechanical), the use of any mechanical device that restricts the movement of an individual's limbs or body and that cannot be easily removed by the person being restrained;

(CCC) Restraint (physical), physically holding an individual and restricting freedom of movement to restrain temporarily for a period longer than ten (10) minutes an individual who presents a likelihood of physical injury to self or others;

(DDD) Screening, the process in which a trained staff member gathers and evaluates relevant information through an initial telephone or face-to-face interview with a person seeking services in order to determine that services offered by the program are appropriate for the person;

(EEE) Seclusion, placing an individual alone in a separate room with either a locked door or other method that prevents the individual from leaving the room;

(FFF) Sentinel event, a serious event that triggers further investigation each time it occurs. It is typically an undesirable and rare event;

(GGG) Service, the provision of prevention, care, treatment, or rehabilitation to persons affected by mental illness or substance abuse;

(HHH) Sexual abuse, in accordance with 9 CSR 10-5.200;

(III) Staff member/personnel, an employee of a certified organization or a person providing services on a contractual basis on behalf of the organization;

(JJJ) Substance, alcohol or other drugs, or both;

(KKK) Substance abuse, unless the context clearly indicates otherwise, a broad term referring to alcohol or other drug abuse or dependency in accordance with criteria established in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association;

(LLL) Supports, array of activities, resources, relationships and services designed to assist an individual's integration into the community, participation in treatment, improved functioning, or recovery;

(MMM) Treatment, application of planned procedures intended to accomplish a change in the cognitive or emotional conditions or the behavior of a person served consistent with generally recognized principles or practices in the mental health field;

(NNN) Treatment plan, a document which sets forth individualized care, treatment and rehabilitation goals and the specific methods to achieve these goals for persons affected by mental illness or substance abuse, and which details the individual's treatment program as required by law, rules and funding sources;

(OOO) Treatment principle, basic precept or approach to promote the effectiveness of care, treatment and rehabilitation services and the dignity and involvement of persons served; and

(PPP) Verbal abuse, in accordance with 9 CSR 10-5.200.

(3) Singular terms include the plural and vice versa, unless the context clearly indicates otherwise.

AUTHORITY: sections 630.050 and 630.055, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed April 15, 2002, effective Nov. 30, 2002.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

Title 9--DEPARTMENT OF MENTAL HEALTH
Division 10--Director, Department of Mental Health
Chapter 5--General Program Procedures

9 CSR 10-5.190 Criminal Record Review

PURPOSE: This rule establishes standards for obtaining a criminal record review for certain staff in residential facilities, day programs or specialized service operated or funded by the Department of Mental Health.

(1) For the purposes of this rule, residential facilities, day programs and specialized services are divided into two (2) categories, as follows:

(A) Category I. Those that are certified or licensed exclusively by the Department of Mental Health or, although not certified or licensed, are funded by the department. Specifically this category includes:

1. Agencies certified by the Department of Mental Health as community psychiatric rehabilitation programs (CPRP);
2. Agencies certified by the Department of Mental Health in the community-based waiver certification program;
3. Agencies certified by the Division of Alcohol and Drug Abuse;
4. Facilities that have contractual arrangements with the department but are exempt from the department's licensing and certification rules due to accreditation or other reason; and
5. Facilities and day programs which are licensed by the department and do not have a license from another state agency; and

(B) Category II. Those that, in addition to a license or certificate from the Department of Mental Health, have a license or certification from another state agency. Specifically, this category includes facilities licensed by the Division of Aging, the Division of Family Services and the Department of Health; also included are intermediate care facilities/mental retardation (ICF/MR). Facilities and agencies included in Category II are subject to rules regarding criminal record review as promulgated by the state agency which licenses or certifies them and are not subject to sections (2) through (7) of this rule. However such agencies are subject to sections (8), (9), (10) and (11) regarding disqualifying crimes.

(2) This rule applies to--

(A) Staff;

(B) Volunteers who are recruited as part of an agency's formal volunteer program and does not apply to volunteers who assist individuals as a friend would by providing assistance with shopping, transportation, recreation, etc.; and

(C) Members of the providers household who have contact with residents or clients, except for minor children.

(3) Each residential facility, day program or specialized service defined under Category I above shall make an inquiry with the Department of Social Services to determine whether any new employee or volunteer having contact with residents or clients is listed on the Division of Aging's employment disqualification list.

(4) Each residential facility, day program or specialized service defined under Category I above shall conduct a criminal background check with the state highway patrol for new staff and volunteers who have contact with patients, residents or clients. The request for the background check shall not require fingerprints and shall be in accordance with requirements of the state highway patrol under Chapter 43, RSMo. The facility, program or service may use a private investigatory agency to conduct this review.

(5) The criminal background check and inquiry with the Department of Social Services shall be initiated not later than two (2) working days of hiring the employee or selecting the volunteer.

(6) In accordance with section 660.317, RSMo, each residential facility, day program and specialized service included under Category I shall require all new applicants for employment or volunteer positions involving contact with residents or clients to--

(A) Sign a consent form authorizing a criminal record review with the highway patrol, either directly through the patrol or through a private investigator agency;

(B) Disclose his/her criminal history, including any conviction or a plea of guilty to a misdemeanor or felony charge and any suspended imposition of sentence, any suspended execution of sentence or any period of probation or parole; and

(C) Disclose if s/he is listed on the employee disqualification list of the Division of Aging.

(7) Each agency shall develop policies and procedures regarding the implementation of this rule and the disposition of information provided by the criminal record review. At a minimum the guidelines shall address--

(A) Procedures for obtaining the criminal record review;

(B) Procedures for confidentiality of records; and

(C) Guidelines for evaluating information received through the criminal record review which establishes a clear boundary between those convictions which, by statute, must exclude an individual from service, and those convictions which would not automatically exclude an individual.

(8) Convictions which under sections 630.170 and 660.317, RSMo exclude a person from service are the following:

(A) A person who has been convicted of, found guilty of, pled guilty to or nolo contendere to any of the following crimes shall be disqualified from holding any position in the agency:

1. Physical abuse or Class I Neglect of a patient, resident or client; or
2. Furnishing unfit food to patients, residents or clients; and

(B) A person who has been convicted of, found guilty of, pled guilty to or nolo contendere to any of the following crimes shall be disqualified from holding any position having contact with patients, residents or clients in the agency. These

crimes are not disqualifying unless they are felonies, except for failure to report abuse and neglect to the Division of Aging, which is a Class A misdemeanor. The disqualifying crimes are:

1. First or second degree murder;
2. Voluntary manslaughter (includes assistance in self-murder);
3. Involuntary manslaughter;
4. First or second degree assault;
5. Assault while on school property;
6. Unlawful endangerment of another;
7. First or second degree assault of a law enforcement officer;
8. Tampering with a judicial officer;
9. Kidnapping;
10. Felonious restraint;
11. False imprisonment;
12. Interference with custody;
13. Parental kidnapping;
14. Child abduction;
15. Elder abuse in the first degree or the second degree;
16. Harassment;
17. Stalking;
18. Forcible rape;
19. First or second degree statutory rape;
20. Sexual assault;
21. Forcible sodomy;
22. First or second degree statutory sodomy;
23. First or second degree child molestation;
24. Deviate sexual assault;
25. First degree sexual misconduct;
26. Sexual abuse;
27. Endangering the welfare of a child;
28. Abuse of a child;
29. Robbery in the first degree or second degree;
30. Arson in the first or second degree;
31. First or second degree pharmacy robbery;
32. Incest;
33. Causing catastrophe;
34. First degree burglary;
35. Felony count of invasion of privacy;
36. Failure to report abuse and neglect to the Department of Social Services as required under subsection 3 of section 198.070, RSMo; or
37. Any equivalent felony offense.

(9) Any person disqualified from employment under this rule may appeal the disqualification to the department's Exceptions Committee.

(A) The request shall be written and may not be made more than one (1) time every twelve (12) months.

(B) The request may be granted if a clear showing has been made that--

1. The person will not commit any additional acts for which the person had originally been disqualified; and
2. The person will not commit any other acts which would be harmful to a patient, resident or client of a facility, program or service.

(C) The Exceptions Committee may grant the appeal subject to conditions and failure to comply with such conditions may result in the person being again disqualified.

(D) The decision of the Exceptions Committee shall not be subject to appeal.

(E) The right to receive an exception under this subsection shall not apply to persons convicted of any of the following crimes:

1. First or second degree murder;
2. First or second degree statutory rape;
3. Sexual assault;
4. Forcible sodomy;
5. First or second degree statutory sodomy;
6. First or second degree child molestation;
7. Deviate sexual assault;
8. Sexual misconduct involving a child;
9. First degree sexual misconduct;
10. Sexual abuse;
11. Incest;
12. First or second degree endangering the welfare of a child;
13. Abuse of a child;
14. First or second degree pharmacy robbery;
15. First degree burglary; or
16. Forcible rape.

(10) For the purposes of this rule, a verdict of not guilty by reason of insanity (NGRI) is not per se disqualifying. A suspended imposition of sentence (SIS) or suspended execution of sentence (SES) is disqualifying.

(11) A provider shall not hire any person who has committed a disqualifying crime as identified in section (8) of this rule, unless the person has received an exception from the department. However, the provider retains the discretionary authority to deny employment to persons who--

(A) Have committed crimes not identified as disqualifying;

(B) Have received an exception from the Exceptions Committee; or

(C) Have received a verdict of Not Guilty by Reason of Insanity.

AUTHORITY: sections 630.170, 630.710 and 660.317, RSMo Supp. 1997 and 630.655, RSMo 1994. Emergency rule filed Aug. 15, 1997, effective Aug. 28, 1997, expired Feb. 26, 1998. Original rule filed Aug. 15, 1997, effective March 30, 1998. Amended: Filed Oct. 29, 1998, effective May 30, 1999.*

**Original authority: 630.170, RSMo 1980, amended 1982, 1996, 1998; 630.655, RSMo 1980; 630.710, RSMo 1980, amended 1996; and 660.317, RSMo 1996, amended 1997, 1998.*

9 CSR 10-5.200 Report of Complaints of Abuse, Neglect and Misuse of Funds/Property

PURPOSE: This rule prescribes procedures for reporting and investigating complaints of abuse, neglect and misuse of funds/property in a residential facility, day program or specialized service that is licensed, certified or funded by the Department of Mental Health (department) as required by sections 630.135, 630.168, 630.655 and 630.710, RSMo. The rule also sets forth due process procedures for persons who have been accused of abuse, neglect and misuse of funds/property.

(1) The following words and terms, as used in this rule, mean:

(A) Class I neglect, failure of an employee to provide reasonable and necessary services to maintain the physical and mental health of any consumer when that failure presents either imminent danger to the health, safety or welfare of a consumer, or a substantial probability that death or physical injury would result;

(B) Class II neglect, failure of an employee to provide reasonable or necessary services to a consumer according to the individualized treatment or habilitation plan, if feasible, or according to acceptable standards of care. This includes action or behavior which may cause psychological harm to a consumer due to intimidating, causing fear or otherwise creating undue anxiety;

(C) Consumer, individual (client, resident, patient) receiving services directly from any program or facility contracted, licensed, certified or funded by the department;

(D) Misuse of funds/property, the misappropriation or conversion of a consumer's funds or property for another person's benefit;

(E) Physical abuse—

1. Purposefully beating, striking, wounding or injuring any consumer; or

2. In any manner whatsoever mistreating or maltreating a consumer in a brutal or inhumane manner. Physical abuse includes handling a consumer with any more force than is reasonable for a consumer's proper control, treatment or management;

(F) Sexual abuse, any touching, directly or through clothing, of a consumer for sexual purpose or in a sexual manner. This includes but is not limited to:

1. Kissing;

2. Touching of the genitals, buttocks or breasts;

3. Causing a consumer to touch the employee for sexual purposes;

4. Promoting or observing for sexual purpose any activity or performance involving consumers including any play, motion picture, photography, dance, or other visual or written representation; or

5. Failing to intervene or attempt to stop or prevent inappropriate sexual activity or performance between consumers; and

(G) Verbal abuse, using profanity or speaking in a demeaning, non-therapeutic, undignified, threatening or derogatory manner in a consumer's presence.

(2) This section applies to any employee or consumer of any residential facility, day program or specialized service, as defined under section 630.005, RSMo. Facilities, programs and services that are operated by the department are regulated by the department's operating regulations and are not included in this definition.

(A) Any such employee who has reasonable cause to believe that a consumer has been subjected to physical abuse, sexual abuse, misuse of funds/property, class I neglect, class II neglect or verbal abuse while under the care of a residential facility, day program or specialized service that is licensed, certified or funded by the department shall immediately make a verbal or written complaint.

(B) A complaint under subsection (A) above shall be made to the head of the facility, day program or specialized service, and to the department's regional center, supported community living placement office or regional administrator office.

(C) The head of the facility, day program or specialized service shall forward the complaint to—

1. The Division of Family Services if the alleged victim is under the age of eighteen (18); or

2. The Division of Senior Services if the alleged victim is a resident or client of a facility licensed by the Division of Senior Services or receiving services from an entity under contract with the Division of Senior Services.

(D) Failure to report shall be cause for disciplinary action, criminal prosecution, or both.

(3) The head of the facility, day program or specialized service that is licensed, certified or funded by the department shall immediately report to the local law enforcement official any alleged or suspected—

(A) Sexual abuse; or

(B) Abuse or neglect which results in physical injury; or

(C) Abuse, neglect or misuse of funds/property which may result in a criminal charge.

(4) If a complaint has been made under this rule, the head of the facility or program and all employees of the facility, program or service shall fully cooperate with law enforcement authorities and with department employees or employees from other agencies authorized to investigate the complaint. Failure to cooperate may result in contract termination or dismissal of the employee.

(5) A board of inquiry, local investigator assigned by the division, or the department's central investigative unit shall gather facts and conduct an investigation regarding the alleged abuse or neglect. The investigation shall be conducted in accordance with the procedures and timeframes established under the department's operating regulations. Upon completion of its investigation, the board of inquiry, local investigator or central investigative unit shall present its written findings of facts to the head of the supervising facility.

(6) Within ten (10) working days of receiving the final report from the board of inquiry, local investigator or central investigative unit, the head of the supervising facility or department designee shall send to the alleged perpetrator a summary of the allegations and findings which are the basis for the alleged abuse/neglect/misuse of funds or property; the provider will be copied. The summary shall comply with the constraints regarding confidentiality contained in section 630.167, RSMo and shall be sent by regular and certified mail.

(A) The alleged perpetrator may meet with the head of the supervising facility or department designee, submit comments or present evidence; the provider may be present and present comments or evidence in support of the alleged perpetrator. If the alleged perpetrator wishes to have this meeting, s/he must notify the head of the supervising facility or department designee within ten (10) working days of receiving the summary.

(B) This meeting shall take place within ten (10) working days of notification, unless the parties mutually agree upon an extension.

(C) Within ten (10) working days of the meeting, or if no request for a meeting is received within ten (10) working days of the alleged perpetrator's receipt of the summary, the head of the supervising facility or department designee shall make a final determination as to whether abuse/neglect/misuse of funds or property took place. The perpetrator shall be notified of this decision by regular and certified mail; the provider will be copied.

(D) The letter shall advise the perpetrator that they have ten (10) working days following receipt of the letter to contact the department's hearings administrator if they wish to appeal a finding of abuse, neglect or misuse of funds/property.

(E) If there is no appeal, the decision of the head of the supervising facility or department designee shall be the final decision of the department.

(F) The department's effort to notify the alleged perpetrator at his/her last known address by regular and certified mail shall serve as proper notice. The alleged perpetrator's refusal to receive certified mail does not limit the department's ability to make a final determination.

(7) If an appeal is requested, the hearings administrator shall schedule the hearing to take place within thirty (30) working days of the request, but may delay the hearing for good cause shown. At the hearing, the head of the supervising facility or designee, or other department designee shall present evidence supporting its findings of abuse, neglect, misuse of funds/property, or all. The provider or perpetrator may submit comments or present evidence to show why the decision of the head of the supervising facility or department designee should be modified or overruled. The hearings administrator may obtain additional information from department employees as s/he deems necessary.

(8) The decision of the hearings administrator shall be the final decision of the department. The hearings administrator shall notify the perpetrator, and the head of the supervising facility or department designee by certified mail of the decision within fourteen (14) working days of the appeal hearing; the provider will be copied.

(9) The opportunities described in sections (6), (7) and (8) of this rule regarding a meeting with the head of the supervising facility and an appeal before the department's hearings administrator apply also to providers and alleged perpetrators in an investigation of misuse of funds/property.

(10) An alleged perpetrator does not forfeit his/her right to an appeal with the department's hearings administrator when s/he declines to meet with the head of the supervising facility under subsections (6) (A) and (B) of this rule.

(11) If the department substantiates that a person has perpetrated physical abuse, sexual abuse, class I neglect, or misuse of funds/property, the perpetrator shall not be employed by the department, nor be licensed, employed or provide services by contract or agreement at a residential facility, day program or specialized service that is licensed, certified or funded by the department. The perpetrator's name shall be placed on the department Disqualification Registry pursuant to section 630.170, RSMo.

(12) If the department substantiates that a person has perpetrated two (2) counts of verbal abuse, or two (2) counts of class II neglect, or one (1) count of verbal abuse and one (1) count of class II neglect, within a twelve (12)-month period, the perpetrator shall not be employed by the department, nor be licensed, employed or provide services by contract or agreement at a residential facility, day program or specialized service that is licensed, certified or funded by the department. The perpetrator's name shall be placed on the department Disqualification Registry pursuant to section 630.170, RSMo.

(13) In accordance with 9 CSR 10-5.190, no person convicted of specified crimes may serve in facilities or programs licensed, certified or funded by the department.

(14) No director, supervisor or employee of a residential facility, day program or specialized service shall evict, harass, dismiss or retaliate against a consumer or employee because he or she or any member of his or her family has made a report of any violation or suspected violation of consumer abuse, neglect or misuse of funds/property. Penalties for retaliation may be imposed up to and including cancellation of agency contracts and/or dismissal of such person.

AUTHORITY: sections 630.050, 630.135, 630.165, 630.167, 630.168, 630.655 and 630.705, RSMo 2000 and 630.170, RSMo Supp. 2001. Original rule filed Oct. 29, 1998, effective May 30, 1999. Emergency amendment filed March 29, 2002,

effective May 2, 2002, expired Jan. 1, 2003. Amended: Filed March 29, 2002, effective Oct. 30, 2002.

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.135, RSMo 1980; 630.165, RSMo 1980, amended 1996; 630.167, RSMo 1980, amended 1985, 1990, 1993, 1996, 1998; 630.168, RSMo 1980, amended 1987, 1996; 630.170, RSMo 1980, amended 1982, 1996, 1998, 2001; 630.655, RSMo 1980; and 630.705, RSMo 1980, amended 1982, 1984, 1985, 1990, 2000*

9 CSR 10-5.210 Exceptions Committee Procedures

PURPOSE: This rule establishes procedures for requesting an exception from the administrative rules of the Department of Mental Health.

(1) Definition. An exception is a decision by the department not to enforce an administrative rule under the individual circumstances described in the request for an exception and the conditions described in the approval. None of the following are subject matter of an exception:

(A) A contention that the rule is not valid;

(B) A contention that the provider is in fact in compliance with the rule; and

(C) A request for an interpretation of a rule.

(2) Rules Subject to an Exception. Only the following statutes and rules may be the subject of an exception:

(A) Statutes and rules related to crimes that disqualify from employment under section 630.170, RSMo and 9 CSR 10-5.190;

(B) Licensure rules for residential facilities and day programs promulgated under 9 CSR 40;

(C) Certification rules for alcohol and drug abuse programs and psychiatric programs promulgated under 9 CSR 30;

(D) Certification rules under 9 CSR 45 for programs serving persons who are developmentally disabled under the Community Based Waiver Program;

(E) Any other administrative rule promulgated by the Department of Mental Health that specifically allows for an exception.

(3) Who may apply for an exception?

(A) A chief executive officer, or designee, on behalf of a residential facility, day program or specialized service, or an employee thereof.

(B) An individual may request an exception on his or her own behalf with respect to criminal backgrounds under 9 CSR 10-5.190.

(C) A facility operated by the department on behalf of a residential facility, day program or specialized service licensed, operated or funded by the department.

(D) Any other person or entity affected by an administrative rule under subsection (2) (D) of this rule.

(4) How to request an exception.

(A) A person may request an exception by sending to the exceptions committee a written request which—

1. Cites the rule number or statutes number in question;

2. Indicates why and for how long compliance with the rule should be waived; and

3. Is accompanied by supporting documentation, if appropriate.

(B) In addition, the following additional items must be part of a request under 9 CSR 10-5.190 Criminal Record Review.

1. A letter from the offender describing the crime and other factors under paragraphs 1. through 12. of this subsection;

2. A description of the specific crime or crimes;

3. When they occurred;

4. Mitigating circumstances, if any;

5. The sentence of the court, including conviction date, sentence status and release date;

6. Activities and accomplishments since the crime;

7. The names and dates of any rehabilitative services;

8. The type of service and/or program the applicant wishes to provide for mental health clients;

9. Identification of the type of employment or position the applicant wishes to maintain or obtain and the name of the mental health program in which he or she wishes to work or continue working;

10. Changes in personal life since the crime (e.g. marriage, family, and education);

11. References, i.e., written recommendations from at least three (3) persons who verify the applicant's assertions; and

12. Work history, with particular emphasis on work in the mental health field.

(C) Request for exceptions should be sent to Exceptions Committee Coordinator, Office of Quality Management, Department of Mental Health, P.O. Box 687, Jefferson City, MO 65102.

(5) Response. Within forty-five (45) calendar days of receiving a request for an exception, the exceptions committee shall respond in writing.

(A) The committee may approve a request, approve the request with conditions, deny the request or defer a decision pending receipt of additional information.

(B) An approved exception regarding criminal backgrounds under 9 CSR 10-5.190 becomes null and void if the subject changes employment or if there are other changes in the circumstances described in the request.

(6) Decisions of the exceptions committee are not subject to appeal. However persons aggrieved by a decision may modify and repeat a request after ninety (90) days. Persons requesting an exception under 9 CSR 10-5.190 must wait twelve (12) months before repeating a request.

(7) Documentation. A recipient of an exception shall—

(A) Maintain documentation of all approved exceptions and make the documentation available for review upon request by authorized staff of the department; and

(B) Annually send to the exceptions committee documentation which—

1. Addresses whether the exception has been implemented, the exception is still necessary and its effect on services;

2. Is required under the terms and conditions announced in the letter of approval.

(8) The Department of Mental Health will review the approved exceptions at least annually to determine whether the exception has been properly implemented and whether its implementation is having the intended impact on services.

(9) Expiration Date for an Exception.

(A) An exception becomes null and void without any further action by the department under any of the following circumstances.

1. An expiration date is announced in the letter of approval.

2. The subject for whom the exception was granted changes employment.

3. There are changes in other circumstances described in the request.

(B) If an exception expires under this section, it may be renewed by submission of a new request.

(10) Rescinding Decisions. The exceptions committee may rescind any exception if, in its judgment, any of the following occur:

(A) The provider failed to meet a condition of the exception, or to maintain documentation required under section (7);

(B) It is discovered that the request contained misleading, incomplete or false information; or

(C) The exception results in poor quality of care, or risk/harm to a client or resident.

(11) If the committee rescinds an exception, the committee shall provide all concerned parties with a notice of rescission with an effective date. There shall be no appeal of a rescission of an exception.

AUTHORITY: sections 630.050, 630.170 and 630.656 RSMo 2000. Original rule filed Feb. 23, 2001, effective Sept. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.170, RSMo 1980, amended 1982, 1996, 1998; 630.656, RSMo 1995.*

9 CSR 10-5.220 Privacy Rule of Health Insurance Portability and Accountability Act of 1996 (HIPAA)

PURPOSE: This rule alerts providers to the possible HIPAA privacy rule requirements if the provider has determined that it is a covered entity as defined by HIPAA. Once that is established, this rule lists policies and procedures that the HIPAA privacy rule requires for each covered entity.

(1) This rule applies to all programs licensed, certified or funded by the Department of Mental Health.

(2) Definitions:

(A) HIPAA: the Health Insurance Portability and Accountability Act of 1996 (45 CFR Parts 160 and 164) as it relates to privacy.

(B) Protected Health Information (PHI): As defined by HIPAA (45 CRF Section 164.501), PHI is individually identifiable health information that is –

1. Transmitted by electronic media;

2. Maintained in any medium described in the definition of electronic media; or

3. Transmitted or maintained in any other form or medium.

(C) Individually identifiable health information: As defined by HIPAA (45 CRF Section 160.103), individually identifiable health information is any information, including demographic information, collected from an individual that is –

1. Created or received by a health care provider, health plan, employer, or healthcare clearinghouse; and

2. Related to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual, and which identifies the individual, or with respect to which there is reasonable basis to believe that the information can be used to identify the individual.

(D) Business Associate: As defined by HIPAA (45 CFR Section 160.103), a person who, on behalf of the covered entity or provider or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:

1. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or

2. Any other function or activity regulated by this subchapter; or provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

(3) All providers who determine that they qualify as covered entities must comply with the provisions of the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A covered entity is defined as a health care provider, a health plan or a clearinghouse. The effective date of the Privacy Rules is April 14, 2003. **If** this provider is a covered entity, **then** HIPAA requires the appropriate policies and procedures be in place to comply with the HIPAA Privacy Rule. HIPAA requires such policies and procedures to include, but not be limited to, the following topics: Notice of Privacy Practices, Amendment of Protected Health Information (PHI), Client Access to PHI, Accounting of Disclosures, Workforce Training, Verification, Authorization for Disclosures of PHI, HIPAA Complaint Process, Marketing (if applicable), Research (if applicable), Audit and Monitoring of HIPAA compliance, and Business Associates Agreements with those companies providing goods and services which require the disclosure of PHI, etc. Where existing confidentiality protections provided by 42 CFR Part 2, related to the release of alcohol and drug abuse records are greater than HIPAA, then the Department anticipates that the provider will consider any such provision of 42 CFR Part 2 as the guiding law.

AUTHORITY: section 630.050, RSMo 2002. 45 CFR Parts 160 and 164, the Health Insurance Portability and Accountability Act of 1996. Emergency rule filed April 1, 2003, effective April 14, 2003, expires Oct. 14, 2003. Original rule filed April 1, 2003

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 3—Alcohol and Drug Abuse Programs

9 CSR 30-3.022 Transition to Enhanced Standards of Care

PURPOSE: This rule describes procedures for programs currently certified under 9 CSR 30-3.010 through 9 CSR 30-3.610 to transition to enhanced standards of care.

(1) Temporary Waivers. Upon the effective date of this rule, the department shall hereby grant a waiver for one (1) year from those new requirements listed in this section which would involve additional and substantial expense to a program currently certified under 9 CSR 30-3.010 through 9 CSR 30-3.610 of Certification Standards for Alcohol and Drug Abuse Programs.

(A) Temporary waivers shall be limited to the following requirements under 9 CSR 30-3.100 Service Delivery Process and Documentation:

1. Five (5) axis diagnosis by an eligible, licensed practitioner;
2. Provision of community support services;
3. Provision of family therapy and codependency counseling for family members;
4. Transportation provided by the program.

(B) Waivers shall be temporary and time-limited.

1. The initial waiver period of one (1) year may be renewed or extended by the department annually thereafter.
2. The total period of waiver shall not exceed three (3) years unless otherwise determined by the department. For those services funded by the department or provided through a service network authorized by the department, the waiver period for any requirement listed in this section shall end when the department makes available additional funding intended to implement the requirement.

(C) Waivers shall not be granted to programs currently certified under 9 CSR 30-3.810 through 9 CSR 30-3.970 Certification Standards for Comprehensive Substance Treatment and Rehabilitation (CSTAR), as standards for these programs are equivalent to the enhanced standards of care required by new rules.

(2) Other Requirements. In addition to this rule, a program must also comply with 9 CSR 10-7.130 Procedures to Obtain Certification that is applicable to both substance abuse and psychiatric programs.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001 effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.032 Certification of Alcohol and Drug Abuse Programs

PURPOSE: This rule identifies the types of substance abuse programs eligible for certification and the applicable requirements.

(1) Types of Programs. Certification is available for the following types of alcohol and drug abuse programs and services:

(A) Recovery programs including—

1. Detoxification in accordance with a designated level of care. Levels of care include social setting, modified medical, or medical;
2. Outpatient treatment in accordance with designated levels of care. Levels of care include community-based primary treatment, intensive outpatient rehabilitation, and supported recovery;
3. Opioid treatment;
4. Compulsive gambling treatment;
5. Residential treatment;
6. Institutional corrections; and
7. Comprehensive substance treatment and rehabilitation (CSTAR);

(B) Recovery Programs for Specialized Populations. A specialized program for the treatment and rehabilitation of adolescents or women and children must be certified as a CSTAR program;

(C) Offender education and intervention programs including—

1. Substance Abuse Traffic Offender Program (SATOP) offering designated levels of service. For persons age twenty-one (21) and older, levels of service include offender management, offender education, weekend intervention, and clinical intervention. For persons under the age of twenty-one (21), levels of service include offender management, adolescent diversion education, and youth clinical intervention. The department shall also certify regional SATOP training centers.
2. Required Educational Assessment and Community Treatment Program (REACT) offering a Screening and Education level of service;

(D) Prevention program offering designated levels of service. Levels of service include primary prevention, targeted prevention, and prevention resource center.

(2) Applicable Program Standards. The organization must comply with the standards applicable to each program for which certification is being sought.

(3) Other Rules and Standards. In addition to standards for specific programs and services, the organization must comply with other applicable requirements.

(A) The following Core Rules for Psychiatric and Substance Abuse Programs must be met, unless otherwise stipulated in standards for specific programs and services:

1. 9 CSR 10-7.010 Treatment Principles and Outcomes;
2. 9 CSR 10-7.020 Rights, Responsibilities and Grievances;
3. 9 CSR 10-7.030 Service Delivery Process and Documentation;
4. 9 CSR 10-7.040 Quality Improvement;
5. 9 CSR 10-7.050 Research;

6. 9 CSR 10-7.060 Behavior Management;
7. 9 CSR 10-7.070 Medications;
8. 9 CSR 10-7.080 Dietary Services;
9. 9 CSR 10-7.090 Governing Authority and Program Administration;
10. 9 CSR 10-7.100 Fiscal Management;
11. 9 CSR 10-7.110 Personnel;
12. 9 CSR 10-7.120 Physical Plant and Safety;
13. 9 CSR 10-7.130 Procedures to Obtain Certification;
14. 9 CSR 10-7.140 Definitions;
15. 9 CSR 10-5.190 Criminal Record Review; and
16. 9 CSR 10-5.200 Report of Complaints of Abuse and Neglect.
17. 9 CSR 10-5.220 Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(B) The following Certification Standards for Alcohol and Drug Abuse Programs must be met, unless otherwise stipulated in standards for specific programs and services:

1. 9 CSR 30-3.022 Transition to Enhanced Standards of Care;
2. 9 CSR 30-3.100 Service Delivery Process and Documentation; and
3. 9 CSR 30-3.110 Service Definitions and Staff Qualifications for Service Delivery.

(4) Approval of Programs and Sites by the Department, When Required. For those services funded by the department or provided through a service network authorized by the department, the department shall have authority to determine and approve each proposed program and/or site prior to the actual delivery of services, including the geographic location, plan of service delivery, and facility.

(A) Any organization subject to this approval process shall submit written notice to the department regarding the proposed program and/or site(s). The notice must include the following information:

1. A determination of need identifying the unserved or under-served target population and the substance abuse treatment, rehabilitation, and other intervention needs of that population. The department shall consider available data, such as current accessibility to and availability of services, prevalence of substance abuse among the target population, applicable emergency room visits and relevant arrest data;
2. A proposed plan of service delivery including, but not limited to, geographic location, facility, services offered, and staffing pattern;
3. A business/capitalization plan demonstrating the organization's financial ability to provide the proposed services to the target population;
4. A description of planning and coordination to meet the needs of the target population in areas such as psychiatric services, housing, etc.; and
5. Documentation of the local community's involvement in and support for the proposed service, such as an advisory committee which includes representatives from the target population and local agencies (such as courts, Board of Probation and Parole, Division of Family Services, mental health providers) with evidence of their involvement via letters of support, minutes of meetings, etc.

(B) An organization which wishes to change its approved program and/or site(s) must obtain approval from the department prior to such change. Any new or different facility must be equal to or better than the original facility.

(C) All opioid treatment programs shall meet the program and/or site approval requirements of this rule, as well as the requirements specified under 9 CSR 30-3.132.

AUTHORITY: sections 302.540, RSMo Supp. 2001 and 630.050, 630.655 and 631.102, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed March 8, 2002, effective Sept. 30, 2002.*

**Original authority: 302.540, RSMo 1983, amended 1984, 1993, 1996, 2001; 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.102, RSMo 1997.*

9 CSR 30-3.100 Service Delivery Process and Documentation

PURPOSE: This rule describes requirements in the delivery and documentation of services for those programs certified under 9 CSR 30-3.120 through 9 CSR 30-3.199.

(1) Other Requirements. In addition to the requirements of this rule, a program must also comply with 9 CSR 10-7.030 Service Delivery Process and Documentation that is applicable to both substance abuse and psychiatric programs.

(2) Available Services. Assessment, individual counseling, group education and counseling, community support and family therapy shall be available to each person participating in substance abuse treatment and rehabilitation in accordance with the individual's clinical needs. Day treatment shall be provided if indicated by the person's level of care.

(3) Services to Family Members. Services shall be available to family members of those persons participating in substance abuse treatment and rehabilitation.

(A) Available services shall include family therapy and individual and group codependency counseling. Groups may include both family members and primary clients when indicated by the goals, content and methods of the group.

(B) Family members shall be routinely informed of available services, and the program shall demonstrate the ability to effectively engage family members in a recovery process.

(C) The program shall not be required to establish a client record for a family member, if group education is the only service provided to the family member and if this service is funded by the department or provided through a service network authorized by the department. However, the program shall be required to maintain documentation of group education services and the participating family members.

(4) Services to Women. A program that lacks certification as a specialized program for women and children must meet the following requirements in order to provide services to women:

(A) Offer gender specific groups which address therapeutic issues relevant to women; and

(B) Have staff with experience and training in the treatment of women.

(5) Services to Adolescents. A program that lacks certification as a specialized program for adolescents must meet the following requirements in order to provide services to adolescents—

(A) Offer groups specifically for adolescents;

(B) Have staff with experience and training in the treatment of adolescents;

(C) Maintain an affiliation agreement and demonstrate an effective working relationship with a certified adolescent program; and

(D) Obtain clinical utilization review authorization that the adolescent may participate in services. Services are limited to the supported recovery level, unless otherwise authorized by clinical utilization review.

(6) Assessment. Each person with a substance abuse problem shall have an assessment by a qualified substance abuse professional in order to ensure an appropriate level of care and an individualized plan.

(A) The assessment shall be completed within seventy-two (72) hours for residential clients or the first three (3) outpatient visits.

1. The seventy-two (72)-hour period for residential clients does not include weekends and holidays observed by the state of Missouri.

2. The initial treatment plan for the individual must also be completed within this designated time period.

(B) If there is a history of prior services in a substance abuse treatment program or a psychiatric facility, a request for prior treatment records shall be made upon written consent of the client or legal guardian to access the department's client tracking registration admissions and commitments system.

(7) Diagnosis. Eligibility for services shall include a diagnosis of substance abuse or dependency including all five (5) axis as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association.

(A) A face-to-face diagnostic interview shall be conducted as part of the assessment by a licensed physician, licensed psychologist, licensed clinical social worker, or licensed professional counselor.

(B) A diagnostician must also have at least one (1) year experience in treating persons with substance disorders.

(8) Transportation and Supports. Transportation shall be provided or arranged by the program to promote participation in treatment and rehabilitation services and to access other resources and supports in the community. Supports that are funded by the department (such as housing or child care) shall meet contractual and other applicable regulatory requirements.

(9) Program Schedule. A current schedule of groups and other structured program activities shall be maintained.

(A) Each person shall actively participate in the program schedule, with individualized scheduling and services based on the person's treatment goals, level of care, and physical, mental, and emotional status.

(B) Group sessions shall address therapeutic issues relevant to the needs of persons served. Some of these scheduled group sessions may not be applicable to or appropriate for all persons and should be attended by each individual on a designated or selective basis. Examples of designated or selective groups may include parenting, budgeting, anger management, domestic violence, co-occurring disorders, relapse intervention track, etc.

(10) Therapeutic Setting. Services shall be provided in a therapeutic, alcohol and drug-free setting.

(A) Productive, meaningful, age-appropriate alternatives to substance use shall be encouraged for each individual.

(B) Any incident of client use of alcohol or drugs shall be documented in the client's record.

(C) An incident of possession or use of alcohol or drugs may result in termination from the program, particularly in residential settings.

(D) Repeated incidents of possession or use shall result in termination from the program.

(E) The program shall not allow gambling or wagering on its premises or as part of its activities.

(11) Drug Testing. The program should conduct tests to determine and detect a client's use of alcohol and drugs. The program shall identify its goals, policies and procedures regarding drug testing.

(A) The program shall implement written policies and procedures regarding the collection and handling of specimens. Urine or other specimens shall be collected in a manner that communicates respect for persons served while taking reasonable steps to prevent falsification of samples.

(B) A laboratory which analyzes specimens shall meet all applicable state and federal laws and regulations.

(C) The program shall implement written policies and procedures outlining the interpretation of results and actions to be taken when the presence of alcohol and/or drugs has been determined.

(D) Test results shall be addressed with persons served once the results are available, in order to intervene with substance use behavior. Test results and actions taken shall be documented in the client's record.

(12) A qualified diagnostician as defined under section (7) of this rule shall approve the treatment plan.

(13) Reviewing Treatment Goals and Outcomes. The individual treatment plan shall be reviewed on a periodic basis and shall accurately reflect the person's needs and goals. Persons who receive services funded by the department or through a service network authorized by the department shall participate in continuing reviews of their progress and outcomes

and updates of their plans within the following time frames:

(A) Ten (10) days for residential treatment and community-based primary treatment;

(B) Thirty (30) days for intensive outpatient rehabilitation;

(C) Ninety (90) days for other levels of care.

(14) Clinical Utilization Review. Services are subject to clinical utilization review when funded by the department or provided through a service network authorized by the department. Clinical utilization review shall promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definitions.

(A) The department shall have authority in all matters subject to clinical utilization review including client eligibility and service definition, authorization, and limitations.

(B) Any service matrix or package that is developed by the department or its authorized representative shall include input from service providers.

(C) Clinical utilization review shall include, but is not limited to, the following situations regarding an individual client:

1. Length of stay beyond any specified maximum time period;

2. Service authorization beyond any specified maximum amount or cost;

3. Admission of adolescents into adult programs; and

4. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by the division.

(D) Clinical utilization review may be required of any client's situation and needs prior to initial or continued service authorization.

(E) The need for clinical utilization review may be identified and initiated by a provider, an individual client, or by the department.

(F) Clinical utilization review may include, but is not limited to, the following situations regarding a program:

1. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by the division regarding the utilization of particular services and total service costs; and

2. Compliance issues related to certification standards or contract requirements that can reasonably be monitored through clinical review.

(15) Credentialed Staff. Clinical utilization review shall be conducted by credentialed staff with relevant professional experience.

(16) Procedures for Clinical Utilization Review. Procedures shall be made available to all affected programs and services.

(A) Reviews shall be completed in a timely manner not to exceed three (3) working days from the time a request is received.

(B) To the extent feasible, a review request from a provider shall be made prior to the delivery of services.

1. No request made more than ninety (90) days after service provision shall be accepted or authorized by the department.

2. The provider is fully responsible for sending all pertinent information and documentation related to a clinical utilization review request.

(C) It is the responsibility of the provider to request a review regarding the appropriateness of admission and treatment services, if a provider considers a client to meet some but not all admission criteria or if any reasonable question may exist or be raised about client eligibility for services.

(D) The department may require or initiate clinical utilization review of any situation related to client eligibility.

(E) Service authorization for a client may be continued, increased, reduced, or discontinued in accordance with a clinical utilization review decision.

(F) When a review determines that services have been inappropriate, unnecessary, or delivered to a client who does not meet eligibility and admission criteria, all service authorization for the client may be discontinued and any other necessary action may be taken.

(G) The department shall establish procedures for the review and appeal of an adverse clinical utilization review action. The provider may deliver services to the client during a review or appeal period, with the understanding that such services may not be authorized or funded. A provider or client may—

1. Request further review of an adverse action. The request must be in writing, identify the clinical factors warranting further review, and be received or postmarked within fifteen (15) days of the initial clinical utilization review action; and

2. Appeal any clinical utilization review decision to discontinue all service authorization for the client.

A. The appeal must be in writing, identify the reason for the appeal, and be received or postmarked within thirty (30) days of receiving notice that service authorization has been discontinued.

B. The department shall designate an Appeal Panel to make a final determination in the matter. The panel shall include one (1) or more representatives who are not staff members of the department and shall include at least one (1) member who is a substance abuse treatment provider.

C. Unless otherwise determined by the panel, its final decision shall be based on information available at the time of the initial clinical utilization review action.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.110 Service Definitions and Staff Qualifications

PURPOSE: This rule defines and describes services provided at treatment and rehabilitation programs certified under 9 CSR 30-3.

(1) Other Requirements. Services shall be provided in accordance with applicable program rules. Limitations on group size that are specified in this rule shall apply to those services funded by the department or provided through a service network authorized by the department.

(2) Available Services. Individual counseling, group education and counseling, community support, and family therapy shall be available to each person participating in substance abuse treatment and rehabilitation in accordance with the individual's clinical needs. Day treatment shall be provided if indicated by the person's level of care.

(3) Services to Family Members. Services shall be available to family members of those persons participating in substance abuse treatment and rehabilitation funded by the department or provided through a service network authorized by the department.

(A) Available services shall include family therapy and individual and group codependency counseling.

(B) Family members shall be routinely informed of available services, and the program shall demonstrate the ability to effectively engage family members in a recovery process.

(4) Services shall be designed and organized to promote peer support and to orient clients and family members to self-help groups.

(5) Individual Counseling. Individual counseling is a structured, goal-oriented therapeutic process in which an individual interacts on a face-to-face basis with a counselor in accordance with the individual's rehabilitation plan in order to resolve problems related to substance abuse which interferes with the person's functioning.

(A) Key service functions of individual counseling may include, but are not limited to:

1. Exploration of an identified problem and its impact on functioning;
2. Examination of attitudes, feelings, and behaviors that promote recovery and improved functioning;
3. Identification and consideration of alternatives and structured problem-solving;
4. Decision making; and
5. Application of information presented to the individual's life situation in order to promote recovery and improved functioning.

(B) Individual counseling shall only be performed by a qualified substance abuse professional or an associate counselor.

(6) Family Therapy. Family therapy is a planned, face-to-face, goal-oriented therapeutic interaction with a qualified staff member in accordance with an individual rehabilitation plan. The purpose of family therapy is to address and resolve problems in family interaction related to the substance abuse problem and recovery.

(A) One (1) or more family members must be present at all family therapy sessions. In any calendar month, for fifty percent (50%) of a client's family therapy, the primary client must be present, in addition to one (1) or more members of the client's family.

1. Family members below the age of twelve (12) may be counted as one (1) of the required family members when the child can be shown to have the requisite social and verbal skills to participate in and benefit from the service.
2. Documentation of family therapy shall identify the family member(s) present and their relationship to the client.

(B) Key service functions of family therapy may include, but are not limited to:

1. Utilization of generally accepted principles of family therapy to influence family interaction patterns;
2. Examination of family interaction styles and identifying patterns of dysfunctional behavior;
3. Development of a need or motivation for change in family members;
4. Development and application of skills and strategies for improvement in family functioning; and
5. Generalization and stabilization of change to promote healthy family interaction independent of formal helping systems.

(C) Family therapy may be provided in either the office or home setting. Family therapy shall not include driving time to and from the home setting.

(D) Family therapy shall be performed by a person who—

1. Is licensed in Missouri as a marital and family therapist; or
2. Is certified by the American Association of Marriage and Family Therapists; or
3. Has a doctoral degree or master's degree in psychology, social work or counseling and has at least one (1) year of supervised experience in family counseling and has specialized training in family counseling; or
4. Has a doctoral degree or master's degree in psychology, social work or counseling and receives close supervision from an individual who meets the requirements of paragraph 1., 2., or 3. of subsection (5) (D); or
5. Is a degreed, qualified substance abuse professional who receives close supervision from an individual who meets the requirements of paragraph 1., 2., or 3. of subsection (5) (D).

(7) Codependency Counseling. Codependency counseling is a planned, face-to-face, goal-oriented therapeutic interaction with an individual or a group to address dysfunctional behaviors and life patterns associated with being a member of a family in which an individual has a substance abuse problem and is currently participating in treatment for substance abuse.

(A) Codependency counseling—

1. Shall be provided only to a person who is a member of a client's family; and

2. May be provided on an individual or a group basis.

(B) Key service functions may include, but are not limited to:

1. Exploration of the substance abuse problem and its impact on family functioning;

2. Development of coping skills and self-responsibility for changing dysfunctional patterns of relationships;

3. Examination of attitudes and feelings and long-term consequences of living with a person with a substance abuse problem;

4. Identification and consideration of alternatives and structured problem-solving;

5. Productive and functional decision-making; and

6. Generalization of newly learned information and behavior to other life situations in order to promote improved family or personal functioning.

(C) The usual and customary size of group codependency counseling sessions shall not exceed twelve (12) family members in order to promote participation, disclosure and feedback.

1. In no event shall the size of a group codependency counseling session that includes only family members exceed an average of twelve (12) persons per calendar month.

2. The program may structure some sessions to include both family members and primary clients up to a maximum of twenty (20) persons.

3. Primary clients participating in such sessions shall be considered, for funding purposes, to have received either day treatment or group counseling, depending on the client's level of care.

(D) Individual and group codependency counseling shall be provided by a person who meets requirements as a—

1. Family therapist; or

2. Qualified substance abuse professional with training in family recovery.

(8) Codependency counseling with children services shall be delivered in an age-appropriate manner. Group codependency services shall be provided in groups with similar ages and developmental issues.

(A) Assessments, individual counseling and group counseling services provided to children under age twelve (12) shall be provided by—

1. A social worker, counselor, psychologist or physician licensed in Missouri who has at least one (1) year of full-time experience in the assessment and treatment of children; or

2. A graduate of an accredited college or university with a master's degree in social work, psychology, counseling, psychiatric nursing or closely related field, which has at least two (2) years of full-time equivalent experience in the treatment and assessment of children.

(B) Group codependency services of an educational nature for children under age twelve (12) shall be provided by a graduate of an accredited college or university with a bachelor's degree in counseling, psychology, social work or closely related field.

(C) Codependency counseling for family members below the age of five (5) may only be given when the child can be shown to have the requisite social and verbal skills to participate in and benefit from the service.

(9) Group Counseling. Group counseling is face-to-face, goal-oriented therapeutic interaction among a counselor and two (2) or more clients as specified in individual rehabilitation plans designed to promote clients' functioning and recovery through personal disclosure and interpersonal interaction among group members.

(A) Key service functions of group counseling may include, but are not limited to:

1. Facilitating individual disclosure of issues which permits generalization of the issue to the larger group;

2. Promoting positive help-seeking and supportive behaviors;

3. Encouraging and modeling productive and positive interpersonal communication; and

4. Developing motivation and action by group members through peer pressure, structured confrontation and constructive feedback.

(B) The usual and customary size of group counseling sessions shall not exceed twelve (12) clients in order to promote client participation, disclosure and feedback. In no event shall the size of group counseling sessions exceed an average of twelve (12) clients per calendar month.

(C) Group counseling services shall be provided by a qualified substance abuse professional or an associate counselor.

(10) Group Education. Group education consists of the presentation of general information and application of the information to participants through group discussion in accordance with individualized rehabilitation plans which is designed to promote recovery and enhance social functioning.

(A) Key service functions of group education may include, but are not limited to:

1. Classroom style didactic lecture to present information about a topic and its relationship to substance abuse;

2. Presentation of audiovisual materials which are educational in nature with required follow-up discussion;

3. Promotion of discussion and questions about the topic presented to the individuals in attendance; and

4. Generalization of the information and demonstration of its relevance to recovery and enhanced functioning.

(B) The usual and customary size of group educational sessions shall not exceed thirty (30) clients in order to promote client participation. In no event shall the size of group education sessions exceed an average of thirty (30) clients per calendar month.

(C) Group education services shall be provided by an individual who—

1. Is suited by education, background or experience to teach the information being presented;

2. Demonstrates competency and skill in educational techniques;

3. Has knowledge of the topic(s) being taught; and

4. Is present with clients throughout the group education session.

(D) In addition, staff that provide information about human immuno-deficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) shall have completed a department approved or comparable training program.

(11) Community Support. Community support consists of specific activities with or on behalf of a particular client in accordance with an individual rehabilitation plan to maximize the client's adjustment and functioning within the community while achieving sobriety and sustaining recovery, maximizing the involvement of natural support systems, and promoting client independence and responsibility.

(A) Key service functions of community support include:

1. Participating in the inter-disciplinary team meeting in order to identify strengths and needs related to development of the individual's rehabilitation plan;
2. Attending periodic meetings with designated team members and the client, whenever feasible, in order to review and update the rehabilitation plan;
3. Contacting clients who have unexcused absence from the program in order to re-engage the person and promote recovery efforts;
4. Arranging and referring for services and resources and, when necessary, advocating obtaining the services and quality of services to which the person is entitled;
5. Monitoring service delivery by providers external to the program and ensuring communication and coordination of services;
6. Locating and coordinating services and resources to resolve a crisis;
7. Providing experiential training in life skills and resource acquisition;
8. Providing information and education to an individual in accordance with the person's rehabilitation plan; and
9. Planning for discharge.

(B) The following activities shall not be considered a community support unit of service:

1. Reviewing a client's record to ensure that documentation is complete or to conduct quality assurance or other program evaluation;
2. Preparing documentation for the department's management information system or for the client's record, such as progress notes, assessment reports, rehabilitation plans and updates, and initial service plans;
3. Preparing and making clinical utilization review requests;
4. Administering client medications or observing clients self-administer medications;
5. Collecting and processing urine or other specimens for purposes of drug testing;
6. Transporting clients to and from the program;
7. Transporting clients to appointments or other locations in the community, unless the presence of the community support worker is required to resolve an immediate crisis or to address a clearly documented need which the client has previously demonstrated an inability to resolve on his/her own;
8. Routinely visiting the client in the home, unless such visit(s) is clearly and directly related to the rehabilitation plan goals;
9. Meetings with other program staff, except scheduled meetings to develop the initial treatment plan and scheduled treatment plan reviews; and
10. Discussions with the client regarding treatment issues that would be more appropriately addressed by individual counseling, group counseling or education, or other available services.

(C) A client must be reasonably involved in other treatment and rehabilitation services in order to be eligible for community support on an ongoing basis.

(D) The program's staffing pattern and arrangements to provide community support services shall be responsive to the needs, goals and outcomes expected for clients.

(E) Community support services shall be provided by a person who has a bachelor's degree from an accredited college or university in social work, psychology, nursing or a closely related field. Equivalent experience may be substituted on the basis of one (1) year for each year of required educational training.

(12) Day Treatment. Day treatment consists of a comprehensive package of services and therapeutic structured activities provided consistent with an individual rehabilitation plan which are designed to achieve and promote recovery from substance abuse and improve functioning.

(A) Key service functions of day treatment include, but are not limited to, the following:

1. Activities to address the person's immediate need to abstain from substance use;
2. Activities and structure which provide a meaningful, constructive alternative to substance abuse;
3. Activities which promote individual responsibility for recovery;
4. Activities that enhance life skills;
5. Activities that address functional skills;
6. Activities that enhance the use of personal support systems; and
7. Activities which promote development of interests and hobbies to constructively use leisure time.

(B) Required service components which will be used to achieve key service functions of day treatment include:

1. Individual counseling;
2. Group counseling;
3. Group education; and
4. Supervision of clients in structured programming to promote and reinforce a substance-free lifestyle including, but not limited to, organized recreational activities, skill building, structured self-study sessions, promotion of self-help and peer support activities.

(C) The ratio of clients to staff for day treatment shall not exceed the maximum established elsewhere in this rule for group counseling and education.

(13) Ratio of Qualified Substance Abuse Professionals. A majority of the program's staff who provide individual and group counseling shall be qualified substance abuse professionals.

(14) Supervision of Associate Counselors. If an associate counselor provides individual or group counseling, the person shall be registered with and recognized by the Missouri Substance Abuse Counselor's Certification Board, Inc. or by an appropriate board of professional registration within the Department of Economic Development. All counselor functions performed by an associate counselor shall be performed pursuant to the supervisor's control, oversight, guidance and full professional responsibility.

(A) The supervisor shall review and countersign documentation in client records made by the trainee.

(B) Documentation which must be countersigned includes assessments, treatment plans and updates, and discharge summaries.

(15) Credentials for Supervisor of Counselors. Unless otherwise required by these rules, supervision of counselors must be provided by a qualified substance abuse professional that has—

(A) A degree from an accredited college in an approved field of study; or

(B) Four (4) or more years employment experience in the treatment and rehabilitation of persons with substance abuse problems.

(16) Credentials for Supervisor of Community Support Workers. A community support worker shall be supervised by an individual with—

(A) A master's degree from an accredited college or university in social work, counseling, psychology or a closely related field and at least one (1) year of full-time equivalent experience in providing community support services; or

(B) A bachelor's degree from an accredited college or university in social work, counseling, psychology or a closely related field and at least two (2) years of full-time equivalent experience in providing community support services; and

(C) Demonstrated competencies in the areas of supervision and substance abuse treatment and rehabilitation by virtue of experience and/or training.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980, and 631.010, RSMo 1980.*

9 CSR 30-3.120 Detoxification

PURPOSE: This rule describes the goals, eligibility and discharge criteria, levels of care, and performance indicators for detoxification programs.

(1) Goals. Detoxification is the process of withdrawing a person from alcohol, other drugs or both in a safe, humane, and effective manner. The goals of detoxification services are to help persons become—

(A) Alcohol and drug-free in a safe manner without suffering severe physical consequences of withdrawal. Medical services shall be provided or arranged, when clinically indicated; and

(B) Involved in continuing treatment. Each person shall be oriented to treatment resources and recovery concepts and shall be assisted in making arrangements for continuing treatment.

(2) Screening. Upon initial contact, a person shall be screened by a trained staff member and assigned to a level of care based on the signs and symptoms of intoxication, impairment or withdrawal, as well as factors related to health and safety.

(A) A screening protocol approved by a physician shall be used to evaluate the person's physical and mental condition and to guide the level of care decision. The department may require, at its option, the use of a standardized screening protocol for those services funded by the department or provided through a service network authorized by the department.

(B) The assigned level of care shall have the ability to effectively address the person's physical and mental condition.

(3) Eligibility Criteria. In order to be eligible for detoxification services, a person must present symptoms of intoxication, impairment or withdrawal and also must require supervision and monitoring of their physical and mental status to ensure safety. A person qualifies for detoxification services on a residential basis if one or more of the following additional criteria are met:

(A) Demonstrates a current inability to minimally care for oneself;

(B) Lacks a supportive, safe place to go and demonstrates a likelihood of continued use of alcohol or other drugs if free to do so;

(C) Requires ongoing observation and monitoring of vital signs due to a prior history of physical complications associated with withdrawal or the severity of current symptoms of intoxication, impairment or withdrawal; or

(D) Presents a likelihood of harm to self or others as a result of intoxication, impairment or withdrawal.

(4) Certified Levels of Care. A person shall be assigned to one (1) of the following levels of detoxification service in accordance with the screening protocol and admission criteria. An agency may offer and be certified for one (1) or more of the following levels of detoxification service:

(A) Social Setting Detoxification. This level of care is offered by trained staff in a residential setting with services and admission available twenty-four (24) hours per day, seven (7) days per week.

1. Medical personnel are not available on-site to prescribe, dispense or administer medications or to diagnosis and treat health problems.

2. A person, who is admitted to social setting detoxification with medication for an established physical or mental health condition, may continue to self-administer his or her medication;

(B) Modified Medical Detoxification. This level of care is offered by medical staff in a non-hospital setting with services and admission available twenty-four (24) hours per day, seven (7) days per week.

1. Routine medical services are provided, and medications are used, when clinically indicated, to alleviate symptoms of intoxication, impairment or withdrawal.

2. A registered or licensed nurse is on duty at all times. Licensed nursing staff receives clinical supervision by a registered nurse.

3. There is on call at all times a physician or an advanced practice nurse licensed and authorized to title and practice as an advanced practice nurse pursuant to section 335.016, RSMo and who is engaged in a written collaborative practice arrangement as defined by law.

(C) Medical Detoxification. This level of care is offered by medical staff in a licensed hospital with services and admission available twenty-four (24) hours per day, seven (7) days per week. Emergency and non-emergency medical services are provided, and medications are used, when clinically indicated, to alleviate symptoms of impairment or withdrawal.

(5) Safety and Supervision. All detoxification services shall be provided in a humane manner and shall ensure the safety and well-being of persons served.

(A) There shall be monitoring and assessment of the person's physical and emotional status during the detoxification process.

1. Vital signs shall be taken on a regular basis, with the frequency determined by client need based on a standardized assessment instrument.

2. Blood alcohol concentration may be monitored upon admission and thereafter as indicated. Further testing of urine or blood may be conducted by qualified personnel.

(B) Staff coverage in residential settings shall ensure the continuous supervision and safety of clients.

1. Two (2) staff members shall be on-site at all times, and additional staff may be required, as warranted by the size of the program and the responsibilities and duties of staff members.

2. Staff providing direct supervision and monitoring of clients shall demonstrate competency in recognizing symptoms of intoxication, impairment and withdrawal; monitoring vital signs; and understanding basic principles and resources for substance abuse treatment.

3. Clients shall be supervised at all times by a staff member with current certification in first aid and cardiopulmonary resuscitation.

(6) Continuing Treatment. Detoxification services shall actively encourage each person to address substance abuse issues and to make arrangements for continuing treatment. There shall be documentation of services delivered and arrangements for continuing treatment. A comprehensive assessment and master treatment plan are not required during detoxification.

(A) Information and education shall be given to each person regarding substance abuse issues.

(B) Individual and group sessions shall be provided, and each person shall be expected to participate in these sessions, to the extent warranted by their physical and mental status.

(C) Each person shall be encouraged to make plans for continuing treatment.

1. Staff shall assist in making referrals and other arrangements, as needed.

2. Any client refusal of treatment services or referrals shall be documented.

(D) A qualified substance abuse professional shall be available and involved in providing individual and group sessions and making arrangements for continuing treatment.

(7) Discharge Criteria. A person shall be successfully discharged or transferred from the detoxification service when they are physically and mentally able to function without the supervision, monitoring and support of this service.

(8) The program handles applications for civil detention of intoxicated persons in accordance with sections 631.115, 631.120 and 631.125, RSMo 2000 unless a waiver is granted in writing by the department.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Oct. 15, 2001, effective April 30, 2002. Amended: Filed April 15, 2002, effective Nov. 30, 2002.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.130 Outpatient Treatment

PURPOSE: This rule describes the levels of outpatient care that may be certified and the goals, eligibility criteria, and available services. Discharge criteria and performance indicators for outpatient programs are also identified.

(1) Available Services. An array of services shall be available on an outpatient basis to persons with substance abuse problems and their family members. The program shall provide all services and comply with the functions required under 9 CSR 30-3.110.

(2) Certified Levels of Care. Outpatient services shall be organized and certified according to levels of care. Each of the levels of care shall vary in the intensity and duration of services offered.

(A) The levels of care may include—

1. Community-based primary treatment. This level of care is the most structured, intensive, and short-term service delivery option with services offered on a frequent, almost daily basis;

2. Intensive outpatient rehabilitation. This level of care provides intermediate structure, intensity and duration of treatment and rehabilitation, with services offered on multiple occasions per week;

3. Supported recovery. This level of care provides treatment and rehabilitation on a regularly scheduled basis, with services offered on approximately a weekly basis unless other scheduling is clinically indicated.

(B) All outpatient services and levels of care offered by an organization shall be certified in accordance with this rule. An organization shall be certified as providing one of the following methods of outpatient service delivery:

1. Supported recovery;
2. Intensive outpatient rehabilitation and supported recovery; or
3. Community-based primary treatment, intensive outpatient rehabilitation and supported recovery.

(C) Outpatient services shall be provided in a coordinated manner responsive to each person's needs, progress and outcomes.

1. The organization shall ensure that individuals can access an appropriate level of care.

A. If all three (3) outpatient levels of care are not offered, the organization shall demonstrate that it effectively helps persons to access other levels of care that may be available in the local geographic area, as needed.

B. The organization must demonstrate that it effectively helps persons to access detoxification and residential treatment services, as needed.

2. An organization with multiple service sites shall not be required to offer its certified levels of care at every site, if it can demonstrate that an individual has reasonable access to its levels of care through coordinated service delivery.

3. A light meal shall be served at a site to those individuals who receive services for a period of more than four (4) consecutive hours. Additional meals shall be provided, if warranted by the program's hours of operation.

(3) Individualized Treatment Options. The levels of care shall be used in a manner that provides individualized treatment options and offers service intensity in accordance with the needs, progress and outcomes of each person served.

(A) A person may enter treatment at any level of care in accordance with eligibility criteria.

(B) A person can move from one level of care to another over time in accordance with symptoms, progress, outcomes and other clinical factors.

1. The duration of each level of care shall be time-limited and tailored to the individual's needs.

2. A person may be transferred to a more intensive level of care if there is a continuing inability to make progress toward treatment and rehabilitation goals.

(4) Community-Based Primary Treatment. This level of care is the most structured, intensive, and short-term service delivery option. Structured services shall be offered at least five (5) days per week and should approximate the service intensity of residential treatment.

(A) Eligibility for primary treatment shall be based on—

1. Evidence that the person cannot achieve abstinence without close monitoring and structured support; and
2. Need for frequent, almost daily services and supervision.

(B) Expected outcomes for primary treatment are to—

1. Interrupt a significant pattern of substance abuse;
2. Achieve a period of abstinence;
3. Enhance motivation for recovery; and
4. Stabilize emotional and behavioral functioning.

(C) The program shall offer an intensive array of services each week.

1. Each person shall participate in at least twenty-five (25) hours of service per week, unless contraindicated by the individual's medical, emotional, legal, and/or family circumstances, and unless residential support is provided.
2. Where residential support is provided, each person shall be offered additional structured therapeutic activities in accordance with residential treatment standards.
3. Each person shall participate in at least one (1) hour per week of individual counseling. Additional individual counseling shall be provided, in accordance with the individual's needs.
4. For community-based primary treatment that is funded by the department or provided through a service network authorized by the department, day treatment may be specified as the applicable service for this level of care.

(5) Intensive Outpatient Rehabilitation. This level of care offers an intermediate intensity and duration of treatment. Services should be offered on multiple occasions during each week.

(A) Eligibility for intensive outpatient rehabilitation shall be based on—

1. Ability to limit substance use and remain abstinent without close monitoring and structured support;
2. Absence of crisis that cannot be resolved by community support services;
3. Evidence of willingness to participate in the program, keep appointments, participate in self-help, etc.; and
4. Willingness, as clinically appropriate, to involve significant others in the treatment process, such as family, employer, probation officer, etc.

(B) Expected outcomes for intensive outpatient rehabilitation are to—

1. Establish and/or maintain sobriety;
2. Improve emotional and behavioral functioning; and
3. Develop recovery supports in the family and community.

(C) The program shall offer at least ten (10) hours of service per week.

1. Each person shall be expected to participate in at least ten (10) hours of service per week, unless contraindicated by the individual's medical, emotional, legal, and/or family circumstances.
2. Each person shall participate in at least one (1) hour per week of individual counseling.

(6) Supported Recovery. This level of care offers treatment on a regularly scheduled basis, while allowing for a temporary increase in services to address a crisis, relapse, or imminent risk of relapse. Services should be offered on approximately a weekly basis, unless other scheduling is clinically indicated.

(A) Eligibility for supported recovery shall be based on—

1. Lack of need for structured or intensive treatment;
2. Presence of adequate resources to support oneself in the community;
3. Absence of crisis that cannot be resolved by community support services;

4. Willingness to participate in the program, keep appointments, participate in self-help, etc.

5. Evidence of a desire to maintain a drug-free lifestyle;

6. Involvement in the community, such as family, church, employer, etc.; and

7. Presence of recovery supports in the family and/or community.

(B) Expected outcomes for supported recovery are to—

1. Maintain sobriety and minimize the risk of relapse;

2. Improve family and social relationships;

3. Promote vocational/educational functioning; and

4. Further develop recovery supports in the community.

(C) The program shall offer at least three (3) hours of service per week. Each person shall be expected to participate in any combination of services determined to be clinically necessary.

(7) Continued Services. The treatment episode or level of care shall be reviewed for the appropriateness of continued services if the person presents repeated relapse incidents, a pattern of noncompliance or poor attendance, threats or aggression toward staff or other clients, or failure to comply with basic program rules.

(8) Discharge Criteria. Each person's length of stay in outpatient services shall be individualized based on the person's needs and progress in achieving treatment goals.

(A) An individual should be considered for successful completion and discharge from outpatient services upon—

1. Recognizing and understanding his/her substance abuse problem and its impacts;

2. Achieving a continuous period of sobriety;

3. Absence of immediate or recurring crisis that poses a substantial risk of relapse;

4. Stabilizing emotional problems, when applicable (for example, not experiencing serious psychiatric symptoms, taking psychotropic medication as prescribed, etc.);

5. Demonstrating independent living skills;

6. Implementing a relapse prevention plan; and

7. Developing family and/or social networks which support recovery and a continuing recovery plan.

(B) A person may be discharged from outpatient services before accomplishing these goals if—

1. Commitment to continuing services is not demonstrated by the client; or

2. No further progress is imminent or likely to occur.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Oct. 15, 2001, effective April 30, 2002. Amended: Filed July 29, 2002, effective March 30, 2003.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.132 Opioid Treatment Program

PURPOSE: This rule describes the specific functions, policies and practices required for a methadone treatment program.

(1) Eligibility for Certification and Service Delivery. Prior to delivering opioid treatment services, an agency must apply for and receive provisional certification from the department.

(A) The agency must document the need for new services and must demonstrate community acceptance of the proposed site(s).

1. Determination of the need for new services shall be at the department's sole discretion as the designated state authority responsible for opioid treatment. The determination of need shall be based on applicable data, such as waiting lists, emergency room visits, arrest data, and federal drug use forecasting data.

2. A new site cannot be located within fifty (50) miles of an existing opioid treatment site, unless otherwise indicated by a determination of need.

3. Community acceptance must be solicited within a one (1)-mile radius of any proposed new site. Assurance must be provided to the department of community acceptance, as well as letters of support from local authorities.

(B) An agency applying for provisional certification as an opioid treatment program in the state of Missouri must have provided other certified alcohol and drug services within the state for two (2) years prior to the application.

(C) In order to be certified as an opioid treatment program, the program shall comply with applicable local, state and federal laws and regulations including those under the jurisdiction of the Food and Drug Administration and the Drug Enforcement Administration.

(2) Treatment Goals and Performance Outcomes. Opioid treatment services shall be organized to achieve key goals and performance outcomes.

(A) Key goals shall include—

1. Developing positive and stable functioning in the community with reduced criminal activity and improved employment status;

2. Reducing or eliminating the use of illicit drugs;

3. Stabilizing emotional and behavioral functioning;

4. Improving social and family relationships; and

5. Improving health status and reducing the spread of infectious disease.

(B) Performance outcomes related to these goals shall be measured in a consistent manner. Measures shall include, but are not limited to—

1. Increasing employment and productive activities. Clients should be involved in employment or other productive activities. For those persons who have been in opioid treatment for six (6) months or longer, seventy percent (70%) shall be working, attending job training or school, be a homemaker, or have a medically documented disability; and

2. Reducing or eliminating the use of illicit drugs. Random urine drug screening shall be used to measure the program's effectiveness in helping clients' progress toward this goal.

A. The following aggregate results shall be expected from random urine drug screening conducted each month—

(I) For all clients tested, seventy percent (70%) shall be free of all drugs; and

(II) For those clients tested who have been in opioid treatment for one (1) consecutive year or longer, eighty percent (80%) shall be free of opiates.

B. In calculating these performance outcomes, the following categories of clients may be exempted—

(I) Persons admitted to the program within the past ninety (90) days;

(II) Persons undergoing administrative withdrawal due to program infraction(s) or other circumstance; and

(III) Persons undergoing withdrawal against medical advice.

(C) If a program does not meet a performance outcome listed in subsection (2) (B) of this rule for three (3) consecutive months, it shall be considered a significant deficiency related to quality of care. The department shall—

1. Place the program on administrative review, require submission of a written plan of correction, and monitor performance for at least ninety (90) days; or

2. Issue conditional certification under the provisions of 9 CSR 10-7.130.

(3) Medical Director. The program shall have a medical director who is a physician licensed in Missouri. Responsibilities of the medical director include, but are not limited to:

(A) Ensuring that clients meet admission criteria and receive the required physical examination and laboratory testing;

(B) Prescribing methadone with client input; and

(C) Reviewing and signing the client's initial treatment plan and the comprehensive treatment plan on an annual basis.

(4) Services. The program shall provide a range of treatment and rehabilitation services to address the therapeutic needs of persons served.

(A) Services shall include:

1. Individual counseling, group education, and counseling, family therapy, community support;

2. Medical evaluations; and

3. Use of methadone for medically supervised withdrawal from narcotics and for ongoing opioid treatment.

A. Medically supervised withdrawal means the dispensing of methadone in decreasing doses to an individual in order to alleviate adverse physiological or psychological effects incidental to withdrawal from the continuous or sustained use of narcotics and in order to bring the individual to a drug-free state within a one hundred eighty (180)-day time period.

B. Ongoing opioid treatment means the dispensing of methadone for more than one hundred eighty (180) days in the treatment of an individual for dependence on heroin or other morphine-like drug.

(B) While eventual withdrawal from the use of all drugs, including methadone, may be an appropriate treatment goal, some clients may remain in opioid treatment for relatively long periods of time.

1. Periodic consideration shall be given to withdrawing from continued opioid treatment, when appropriate to the individual's progress and goals.

2. Such consideration and decisions shall be determined by the client and the program staff as part of an individualized treatment planning process.

(C) The program shall offer services at least six (6) days per week. Services shall be available during early morning or evening so that clients who are employed or otherwise involved in productive, daily activities can access services.

(5) Admission Criteria. The program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive. Persons who are not residents of the state of Missouri shall comprise no more than twenty percent (20%) of the clients of the program.

(A) In order to qualify for medically supervised withdrawal, the applicant must demonstrate physiologic dependence to narcotics. Documentation must indicate clinical signs of dependence, such as needle marks, constricted or dilated pupils, etc.

(B) In order to qualify for initial admission to ongoing opioid treatment, the applicant must demonstrate physiologic dependence and continuous or episodic addiction for the one (1)-year period immediately prior to application for admission. Documentation must indicate clinical signs of dependence, past use patterns and treatment history, etc. The following exceptions may be made to the minimum admission requirements for opioid treatment:

1. The program may place a pregnant applicant on a methadone treatment regimen, regardless of age, if the applicant has had a documented dependency on heroin or other morphine-like drugs in the past and may be in direct jeopardy of returning to such dependency, with its attendant dangers during pregnancy. The applicant need not show evidence of current physiologic dependence if a program physician certifies the pregnancy and, in his/her reasonable clinical judgment, justifies opioid treatment;

2. For an applicant who is under the age of eighteen (18), the program shall document two (2) unsuccessful attempts at drug-free treatment prior to admission to ongoing opioid treatment. The program shall not admit any person under the age of sixteen (16) to a program without the prior approval of the Division of Alcohol and Drug Abuse; and

3. An applicant who has been residing in a correctional institution for one (1) month or longer may enroll in a program within fourteen (14) days before

release or discharge or within six (6) months after release from such an institution without evidence of current physiologic dependence on narcotics provided that prior to institutionalization the client would have met the one (1)-year admission criteria.

(C) In order to qualify for readmission to opioid treatment, the applicant must demonstrate current physiologic dependence.

1. The program may waive this requirement if it documents prior opioid treatment of six (6) months or more and discharge within the past two (2) years.

2. At the discretion of its medical director, the program may require an applicant who has received administrative detoxification due to an infraction of program rules to wait a minimum of thirty (30) days prior to applying for readmission.

(D) The medical director may refuse the admission of an applicant and/or opioid treatment to a particular client if, in the reasonable clinical judgment of the medical director, the person would not benefit from such treatment. Prior to such a decision, appropriate staff should be consulted and the reason(s) for the decision must be documented by the medical director.

(6) Admission and Assessment Protocol. The opioid treatment program shall—

(A) Verify the applicant is not currently enrolled in another methadone program;

(B) Obtain the applicant's signature on a consent to treatment, ensuring that the client understands the risks and benefits of opioid treatment and the possibility of administrative detoxification for infractions of program rules;

(C) Conduct a complete medical history and physical examination to determine symptoms of withdrawal and the possibility of infectious disease; and

(D) Obtain laboratory testing to determine—

1. Blood count and differential and chemical profile;

2. Serological test for sexually transmitted disease;

3. Routine and microscope urinalysis;

4. Pregnancy test;

5. Toxicology screening for drugs;

6. Intradermal Purified Protein Derivative (PPD) test, administered and interpreted by medical staff; and

7. A chest X-ray, pap smear, or screening for sickle cell disease if the examining medical personnel request these tests.

(E) A complete medical history, physical examination, and laboratory testing shall not be required for a client who has had such medical evaluation within the prior thirty (30) days. The program shall have documentation of the medical evaluation and any significant findings.

(7) Continued Placement and Utilization Criteria. The program shall utilize a structured approach in providing treatment and rehabilitation services and shall use established criteria for determining client progress. Client progress and movement between the structured phases of treatment shall be based on the following criteria:

(A) Absence of the use of alcohol and other drugs, except as medically prescribed;

(B) Social, vocational, legal, family, emotional and behavioral functioning;

(C) Program attendance as scheduled; and

(D) Other individual goals and accomplishments related to the client's treatment plan.

(8) Phases of Treatment. The program shall utilize six (6) structured phases of treatment and rehabilitation to indicate client progress and to establish requirements regarding client attendance and service participation. The requirements listed below for each phase are minimum requirements and the frequency and extent of treatment and rehabilitation services shall be adjusted, based on individual client needs.

(A) Phase I consists of a minimum ninety (90)-day period in which the client attends the program for observation of opioid treatment daily or at least six (6) days a week. Take-home dosage is limited to a single dose each week.

1. During the initial ninety (90) days, the client shall participate in at least four (4) hours of counseling per month with at least two (2) of the hours being individual counseling.

2. During the initial ninety (90) days, the treatment plan shall be reviewed and updated on at least a monthly basis.

3. Prior to client moving to Phase II or receiving take-home medication, the client shall demonstrate a level of stability as evidenced by absence of alcohol and other drug abuse, regularity of program attendance, absence of significant behavior problems, absence of recent criminal activities, and employment, actively seeking employment or attending school if not retired, disabled, functioning as a homemaker, or otherwise economically stable.

(B) Phase II is designated for clients who have been admitted more than ninety (90) days, but less than two hundred seventy (270) days and who have successfully met Phase I criteria.

1. During the first ninety (90) days of Phase II, the program may issue no more than two (2) take-home doses of methadone at a time.

2. The client shall participate in at least two (2) hours of counseling per month during the first three (3) months of Phase II, with at least one (1) of the hours being individual counseling.

3. During the second ninety (90) days of phase II, the client shall participate in at least one (1) hour of individual counseling per month, and the program may issue no more than three (3) take-home doses of methadone plus closed and holiday days.

4. The treatment plan shall be reviewed and updated at least every three (3) months during Phase II.

(C) Phase III is designated for clients who have been admitted more than nine (9) months but less than one (1) year and who have successfully met progressive Phase II criteria.

1. During Phase III, the program may issue no more than six (6) take-home doses of methadone plus closed and holiday days.

2. The client shall participate in at least one (1) hour of individual counseling per month during Phase III.

3. The treatment plan shall be reviewed and updated at least every six (6) months during Phase III, or more frequently if circumstances warrant.

(D) Phase IV is designated for clients who have been admitted more than one (1) year but less than two (2) years and who have successfully met progressive Phase III criteria.

1. During Phase IV, the program may issue two (2) week take-home doses plus closed and holiday days.

2. The client shall participate in at least one (1) hour of individual counseling per month during this phase.

3. The treatment plan shall be reviewed and updated at least every six (6) months during this phase.

(E) Phase V is designated for clients who have been admitted for more than two (2) years.

1. During Phase V, the program may issue one (1) month maximum take-home doses.

2. The client shall participate in at least one (1) hour of individual counseling per month during this phase.

3. The treatment plan shall be reviewed and updated at least every six (6) months during this phase.

(F) Phase VI is designated for clients who voluntarily seek medically supervised withdrawal and abstinence from all drugs, including methadone as prescribed. A client may enter this phase at any time in the treatment and rehabilitation process.

1. During Phase VI, the medical director determines take-home doses based on stability.

2. During Phase VI, the counselor determines the frequency of counseling sessions with input from the client. At the onset of Phase V, the client may require an increased level of counseling and other support services.

3. The counselor and patient develop an after care plan prior to the successful completion of treatment.

(9) Program Rules. In order to remain in the program and to successfully progress through the phases of treatment and rehabilitation, a client shall demonstrate progress and shall comply with program rules.

(A) An infraction of program rules by a client may result in administrative detoxification withdrawal from methadone and termination from the program.

(B) For the purpose of these standards, an infraction means threats of violence or actual bodily harm to staff or another client, disruptive behavior, community incidents (loitering, diversion of methadone, sale or purchase of drugs), continued unexcused absences from counseling and other support services, involvement in criminal activities and other serious rule violations.

(C) A client who either relapses or ceases to meet the progressive phase criteria for which they have been granted may, at the discretion of the medical director, be moved to a phase that the medical director determines is necessary to reestablish stability.

(10) Safety and Health. The program shall establish and implement policies, procedures, and practices which ensure access to its services and which address the safety and health of its clients. The provider shall—

(A) Ensure continued opioid treatment in the event of emergency or natural disaster;

(B) Ensure treatment to persons regardless of sero status, HIV-related conditions, acquired immunodeficiency syndrome (AIDS), or tuberculosis (TB);

(C) Provide information and education to clients regarding HIV and AIDS;

(D) Provide or arrange HIV testing and pre-test and post-test counseling for clients;

(E) Provide or arrange testing for tuberculosis and sexually transmitted diseases upon admission and at least annually thereafter;

(F) Provide medical evaluations to clients upon admission and at least annually thereafter;

(G) Utilize infection control procedures consistent with Occupational Safety and Health Administration guidelines;

(H) Arrange for medical care to clients during pregnancy, when necessary, and document the arrangements made and the client's compliance.

(11) Staff Training. All direct service and medical staff shall receive training relevant to service delivery in an opioid treatment setting. Each staff member shall participate in fourteen (14) clock hours of such training during a two (2)-year period.

(12) Urine Drug Testing. The program shall use urinalysis testing as a performance measure and as a clinical tool for the purpose of diagnosis and treatment planning.

(A) Each urine sample shall be analyzed for opiates, methadone, amphetamines, cocaine, barbiturates, and benzodiazepines. Testing shall include other drugs as may be indicated by a client's use patterns. In addition, if any other drug or drugs have been determined by a program to be abused in that program's locality, or as otherwise indicated, each test or analysis must include any such drugs.

(B) Drug testing shall be done upon admission, and random drug testing of each client shall be conducted at least eight (8) times during a twelve (12)-month period.

(C) Following admission, the results of a single drug test shall not be the sole basis to determine significant treatment decisions.

(D) A program with thirty percent (30%) or more of its client population having positive drug test results shall be placed on administrative review and the agency shall develop an action plan to bring its program into compliance with this performance expectation.

(13) Take-Home Doses. The program shall implement practices in accordance with the principle that take-home doses of methadone is a privilege given only to those individuals who will benefit from it and who have demonstrated responsibility in taking methadone as prescribed.

(A) The requirement of time in treatment as outlined elsewhere in this rule is a minimum reference point after which a client may be considered for take-home medication privileges. The time reference does not mean that a client in treatment for a particular time has a specific right to take-home medication.

(B) Programs must educate the client regarding safe transportation and storage of methadone as well as emergency procedures in case of accidental ingestion.

(C) Before take-home privileges are allowed, the client must have a lock box for transportation of methadone and home storage.

(D) Regardless of time in treatment, the medical director, in his/her reasonable judgment, may deny or rescind the take-home medication privileges of a client.

(14) Methadone Storage and Security. The program shall ensure the security of its methadone supply and shall account for all methadone.

(A) The program shall meet the requirements of the Drug Enforcement Administration.

(B) The program shall maintain an acceptable security system, and its system shall be checked on a quarterly basis to ensure its continued safe operation.

(C) The program shall physically separate the narcotic storage and dispensing area from other parts of its facility used by clients.

(D) The program shall implement written policies and procedures to ensure positive identification of the client before methadone is administered.

(E) The program shall implement written policies and procedures regarding the recording of client medication intake and a daily methadone inventory.

(15) Emergency Medication. The medical director may, based on his/her reasonable judgment, grant emergency take-home doses of methadone based on emergency circumstances related to medical, criminal justice, family or employment. The circumstances and basis for the action must be documented in the client record and should address the concerns outlined in section (13). Take-home doses for in-state emergencies are limited to a maximum of three (3) doses and out-of-state is limited to a maximum of five (5) doses. Additional take-home doses must be authorized through the exception request process.

(16) Vacation Medication. The program medical director may, based on his/her reasonable judgment grant vacation take-home doses of methadone for up to two (2) weeks per calendar year. The circumstances and basis for the action must be documented in the client record and should address the concerns outlined in section (13). Additional take-home medication must be authorized through the exception request process.

AUTHORITY: sections 630.655 and 631.102, RSMo 2000. This rule originally filed as 9 CSR 30-3.610. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded and readopted: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed July 29, 1997, effective Jan. 30, 1998. Moved to 9 CSR 30-3.132 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Oct. 15, 2001, effective April 30, 2002. Amended: Filed March 8, 2002, effective Sept. 30, 2002.*

**Original authority: 630.655, RSMo 1980 and 631.102, RSMo 1997.*

9 CSR 30-3.134 Compulsive Gambling Treatment

PURPOSE: This rule describes the specific service delivery requirements for compulsive gambling treatment.

Editor's Note: The following material is incorporated into this rule by reference:

1) American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 4th Edition. (Washington, D.C., American Psychiatric Association, 1994).

In accordance with section 536.031(4), RSMo, the full text of material incorporated by reference will be made available to any interested person at the Office of the Secretary of State and the headquarters of the adopting state agency.

(1) Service Functions. The key functions of compulsive gambling treatment and rehabilitation services shall include:

(A) Using generally accepted treatment principles to promote positive changes in gambling behavior and lifestyle;

(B) Exploring the compulsive gambling and its impact on individual and family functioning;

(C) Helping the person to better understand his/her needs and how to constructively meet them;

(D) Teaching effective methods to deal with urges to gamble; and

(E) Enhancing motivation and creative problem solving for both the individual and his/her family.

(2) Treatment Goals and Performance Outcomes. Indicators of positive treatment outcome include the amelioration of gambling behavior, as well as improvements in family relationships, leisure and social activities, educational/vocational functioning, legal status, psychological functioning and financial situation.

(3) Eligibility Criteria. Eligibility for treatment services shall be based on criteria for pathological gambling as defined in the current edition of the

Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. There must be documentation of the specific behaviors and circumstances demonstrating how the person meets each criteria. For persons who receive services funded by the department or through a service network authorized by the department, those instruments stipulated or provided by the department shall be used in the admission process and eligibility determination.

(4) Available Services. Compulsive gambling treatment services shall be offered on an individual, family and group basis in an outpatient setting. Available services shall include individual counseling, group education and counseling, family therapy, and codependency counseling for family members.

(A) Each client shall be oriented to and encouraged to participate in self-help groups and peer support.

(B) Family members of persons with a gambling problem shall be encouraged to participate in a recovery process. Such participation does not include counseling sessions for family members on an ongoing basis to resolve other personal problems or other mental disorders.

(C) The treatment provider shall arrange other services and make referrals to address other problems that the client or the family may have, such as financial problems, substance abuse or other mental disorders.

(5) Service Authorization and Utilization Review. Services shall be subject to authorization and clinical utilization review in accordance with 9 CSR 30-3.100 Service Delivery Process and Documentation.

(6) Definition of Compulsive Gambling Counselor. A compulsive gambling counselor is a person who demonstrates substantial knowledge and skill in the treatment and rehabilitation of compulsive gambling by having completed a designated training program sponsored or approved by the division and being either—

(A) A counselor, clinical social worker, psychologist, or physician licensed in Missouri by the Division of Professional Registration; or

(B) A substance abuse counselor I or II certified by the Missouri Substance Abuse Counselor Certification Board.

(7) Credentialing of Compulsive Gambling Counselors. The department shall issue a compulsive gambling counselor credential to designate those persons who meet the qualifications specified in this rule. This credential shall be a requirement for providing compulsive gambling counseling services eligible for funding by the department.

(A) A person may request an application for this credential from the Department of Mental Health P.O. Box 687, Jefferson City, MO 65102.

1. The department may require an application fee.

2. The applicant must fully complete the application process and must verify that s/he meets all qualifications specified in this rule.

(B) The credential shall be issued for a period of time coinciding with the period of licensure or certification otherwise required of the applicant, up to a maximum period of two (2) years.

(C) The credential may be renewed upon further application and verification that the counselor continues to meet all qualifications. For renewal, the applicant must have received during the past two (2) years at least fourteen (14) hours of training sponsored or approved by the department that is directly related to the treatment of compulsive gambling.

(D) Credentialed counselors shall adhere to the code of ethics for their profession in providing services for compulsive gambling.

1. Any complaint or grievance received by the department regarding a compulsive gambling counselor shall be forwarded to the applicable licensure or certification body.

2. Any sanction arising from a code of ethics violation shall be deemed as applying equally to the compulsive gambling counselor credential.

AUTHORITY: sections 313.842, 630.050 and 630.655, RSMo 2000. This rule originally filed as 9 CSR 30-3.611. Original rule filed Oct. 13, 1995, effective April 30, 1996. Amended: Filed Jan. 10, 1997, effective Aug. 30, 1997. Moved to 9 CSR 30-3.134 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 313.842, RSMo 1991, amended 1996, 2000; 630.050, RSMo 1980, amended 1993, 1995; and 630.655, RSMo 1980.*

9 CSR 30-3.140 Residential Treatment

PURPOSE: This rule describes the goals, eligibility and discharge criteria, available services, and performance indicators for residential treatment.

(1) Treatment Goals. Residential treatment shall offer an intensive set of services in a structured alcohol- and drug-free setting. Services shall be organized and directed toward the primary goals of—

(A) Stabilizing a crisis situation, where applicable;

(B) Interrupting a pattern of extensive or severe substance abuse;

(C) Restoring physical, mental and emotional functioning;

(D) Promoting the individual's recognition of a substance abuse problem and its effects on his/her life;

(E) Developing recovery skills, including an action plan for continuing sobriety and recovery; and

(F) Promoting the individual's support systems and community reintegration.

(2) Eligibility Criteria. In order to fully participate in and benefit from the intensive set of services offered in residential treatment, a person must meet the following admission and eligibility criteria:

(A) Does not demonstrate symptoms of intoxication, impairment or withdrawal that would hinder or prohibit full participation in treatment services. A screening instrument, that includes vital signs, must be used with all prospective

clients to identify symptoms of intoxication, impairment, or withdrawal and, when indicated, detoxification services must be provided or arranged;

(B) Needs an alternative, supervised living environment to ensure safety and protection from harm;

(C) Meets the general treatment eligibility requirement of a current diagnosis of substance abuse or dependence and, in addition, demonstrates one or more of the following—

1. Recent patterns of extensive or severe substance abuse;

2. Inability to establish a period of sobriety without continuous supervision and structure;

3. Presence of significant resistance or denial of an identified substance abuse problem; or

4. Limited recovery skills and/or support system; and

(D) A client may qualify for transfer from outpatient to residential treatment if the person—

1. Has been unable to establish a period of sobriety despite active participation in the most intensive set of services available on an outpatient basis; or

2. Presents imminent risk of serious consequences associated with substance abuse.

(3) Safety and Supervision. The residential setting shall ensure the safety and well-being of persons served.

(A) Staff coverage shall ensure the continuous supervision and safety of clients.

1. There shall be an adequate number of paid staff on duty (awake and dressed) at all times. At least two (2) staff shall be on duty, unless otherwise stipulated in these rules or authorized in writing by the department through the exceptions process. Additional staff shall be required, if warranted by the size of the program and the responsibilities and duties of the staff members.

2. Clients shall be supervised at all times by a staff member with current certification in first aid and cardiopulmonary resuscitation.

(B) The program shall immediately and effectively address any untoward or critical incident including, but not limited to, any incident of alcohol or drug use by a client on its premises.

(4) Intensive Services with Individualized Scheduling. Services shall be responsive to the needs of persons served.

(A) There shall be a current schedule of program activities that offers a minimum of fifty (50) hours of structured, therapeutic activity per week.

1. Therapeutic activities shall be provided seven (7) days per week.

2. Group education and group counseling must constitute at least twenty (20) of the required hours of therapeutic activity per week.

(B) At least one (1) hour of individual counseling per week shall be provided to each client. Additional individual counseling shall be provided, in accordance with the individual's needs.

(5) Discharge Criteria. Each client's length of stay in residential treatment shall be individualized, based on the person's needs and progress in achieving treatment goals.

(A) To qualify for successful completion and discharge from residential treatment, the person should—

1. Demonstrate recognition and understanding of his/her substance abuse problem and its impacts;

2. Achieve an initial period of sobriety and accept the need for continued care;

3. Develop a plan for continuing sobriety and recovery; and

4. Take initial steps to mobilize supports in the community for continuing recovery.

(B) A person may be discharged before accomplishing these goals if maximum benefit has been achieved and—

1. No further progress is imminent or likely to occur;

2. Clinically appropriate therapeutic efforts have been made by staff; and

3. Commitment to continuing care and recovery is not demonstrated by the client.

(6) The program handles applications for continued civil detention in accordance with sections 631.140, 631.145 and 631.150, RSMo 2000.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Oct. 15, 2001, effective April 30, 2002. Amended: Filed April 15, 2002, effective Nov. 30, 2002.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.150 Comprehensive Substance Treatment and Rehabilitation (CSTAR)

PURPOSE: This rule establishes special requirements for service delivery as Comprehensive Substance Treatment and Rehabilitation (CSTAR).

(1) Levels of Care. A CSTAR program shall provide the following levels of care on a nonresidential basis in accordance with requirements for outpatient programs:

(A) Primary treatment;

(B) Intensive outpatient treatment; and

(C) Supported recovery.

(2) Other Applicable Program Requirements. A CSTAR program shall meet the following additional requirements, when the department determines that they are applicable:

(A) Services offered on a residential basis shall comply with requirements for residential treatment; and

(B) Requirements as a specialized program for adolescents or as a specialized program for women and children shall be met, where applicable.

(3) Medicaid Eligibility. An organization must be certified as a CSTAR program in order to qualify for Medicaid reimbursement of substance abuse treatment services to eligible persons.

(A) A CSTAR program shall comply with applicable state and federal Medicaid requirements.

(B) If there is a change in the Medicaid eligibility or financial status of a person served, the individual shall not be prematurely discharged from the CSTAR program or otherwise denied CSTAR services. The program shall—

1. Continue to provide all necessary and appropriate services until the client meets rehabilitation plan goals and criteria for discharge; or

2. Transition the client to another provider such that there is continuity of clinically appropriate treatment services.

(4) Missed Appointments. If an individual fails to appear at a scheduled program activity, staff shall promptly initiate efforts to contact the person and maintain active program participation.

(A) Such efforts should be initiated within forty-eight (48) hours, unless circumstances indicate a more immediate contact should be made due to the person's symptoms and functioning or the nature of the scheduled service.

(B) Efforts to contact the person shall be documented in the individual's record.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.160 Institutional Corrections Treatment Programs

PURPOSE: This rule supplements other rules under this chapter by setting forth rules which are specific to institutional corrections treatment programs.

(1) Program Description. An institutional corrections treatment program shall provide treatment and rehabilitation services to persons with substance abuse problems who are incarcerated by the Missouri Department of Corrections. This rule does not apply to those corrections programs or facilities which provide only educational services regarding substance abuse.

(2) Admission Criteria. The program shall provide treatment and rehabilitation for those persons who—

(A) Meet diagnostic criteria for a substance abuse or dependence as described in the current edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association; or

(B) Have been ordered by a court of jurisdiction or by the Board of Probation and Parole to participate in a substance abuse treatment program in an institutional setting under the auspices of the Department of Corrections.

(3) Treatment Goals. The program shall provide treatment and rehabilitation in a structured, alcohol- and drug-free setting.

(A) Services shall be organized and directed toward the primary goals of—

1. Stabilizing a crisis situation, where applicable;

2. Interrupting a pattern of extensive or severe substance abuse;

3. Restoring physical, mental and emotional functioning;

4. Promoting the individual's recognition of a substance abuse problem and its effects on his/her life;

5. Developing recovery skills, including an action plan for continuing sobriety and recovery; and

6. Promoting the individual's support systems and community reintegration.

(B) The program shall establish a positive, recovery-oriented, supportive treatment setting that emphasizes personal responsibility and accountability and promotes pro-social interaction.

(C) Services shall promote reality-based, cognitive restructuring approaches to address substance abuse and criminality.

(4) Performance Indicators. All programs shall collect and review data related to the goals and outcomes for institutional corrections treatment.

(A) Each program shall collect data on key indicators that may include, but are not limited to, the following:

1. Client satisfaction with services;

2. Number of persons who successfully complete institutional corrections treatment;

3. Number of persons who leave against staff advice or are otherwise unsuccessfully discharged from the program;

4. Number of persons who engage in continuing treatment in the community;

5. Number of persons who commit further offenses in the community upon release or are re-incarcerated in a correctional facility;

6. Number of persons maintaining a drug-free status as determined by laboratory tests to detect the use of alcohol and drugs; and

7. Changes in the functioning of clients (such as employment and other measures of social and emotional functioning).

(B) Each program shall use this data in its quality improvement process.

(C) The Department of Corrections may require, at its option, the use of designated indicators or measures in order to promote consistency and the wider applicability of this data.

(5) Adapting Other Requirements to Institutional Corrections Treatment Programs and Settings. Requirements referenced under 9 CSR 30-3.022 Certification of Alcohol and Drug Abuse Programs shall be applicable to institutional corrections treatment programs and settings, subject to the modifications and adaptations specified in this rule. The program shall comply with the following requirements without modification or adaptation:

(A) 9 CSR 10-7.010 Treatment Principles and Outcomes;

(B) 9 CSR 10-7.040 Quality Improvement;

(C) 9 CSR 10-7.050 Research;

(D) 9 CSR 10-7.090 Governing Authority and Program Administration;

(E) 9 CSR 10-7.100 Fiscal Management;

(F) 9 CSR 10-7.130 Procedures to Obtain Certification;

(G) 9 CSR 10-7.140 Definitions;

(H) 9 CSR 10-5.190 Criminal Record Review; and

(I) 9 CSR 10-5.200 Report of Complaints of Abuse and Neglect.

(6) Service Definitions and Staff Qualifications. Requirements under 9 CSR 30-3.110 Service Definitions and Staff Qualifications are included by reference and are adapted for institutional corrections treatment programs as follows:

(A) The maximum size of educational groups for clients shall be identified in the organization's policy and procedures manual, approved by its governing authority, and stated in its application for certification.

1. In no case shall the size of the educational groups exceed the capacity for comfort, safety and security.

2. Educational groups shall be supplemented with methods such as worksheets, homework assignments or small discussion groups to enhance clients' understanding and internalization of the information presented.

(B) Educational groups for family members should be offered which provide information about substance abuse and its effects on the family. These groups may include family members and significant others who have an ongoing relationship with the individual that affects the continuing recovery plan.

(7) Service Delivery Process and Documentation. Requirements regarding Service Delivery and Documentation under 9 CSR 10-7.030 and 9 CSR 30-3.100 are included by reference and are adapted for institutional corrections treatment programs as follows:

(A) Individual counseling, group education and counseling, recreation and introduction to self-help groups shall be provided to each client;

(B) Community support, family therapy, and codependency counseling are not required services. However, if these services are offered, service delivery shall be in accordance with applicable standards;

(C) The screening process required under 9 CSR 10-7.030(1) is waived. However, it is the program's responsibility to identify and to refer individuals to appropriate Department of Correction services. The program shall—

1. Comply with Department of Corrections' policy for provision of psychological and medical emergency care; and

2. Coordinate services within the Department of Corrections to ensure the individual's safety;

(D) The assessment shall be completed by a qualified substance abuse professional within ten (10) working days of admission to the treatment program to ensure identification of the appropriate level of care and to develop the individualized treatment plan;

(E) The treatment plan shall be also developed within ten (10) working days of admission to the treatment program and shall accurately reflect the individual's needs and goals;

(F) Treatment plans shall be reviewed and updated as follows, unless a more frequent review is stipulated by the court for an individual:

1. Programs with an expected length of stay of six (6) months or less shall review and update treatment plans every forty-five (45) days;

2. Programs with an expected length of stay of more than six (6) months shall review and update treatment plans every ninety (90) days;

(G) Persons involved in the care and treatment of an individual shall participate in a staffing for the purpose of developing, coordinating, and communicating the treatment plan to all applicable parties;

(H) The program shall facilitate access to and cooperation with all necessary services within the institution including access to pertinent medical records;

(I) The program shall conduct or arrange tests to detect a client's use of alcohol and drugs in accordance with certification standards or Department of Corrections policy and procedure;

(J) The program shall provide an intensive phase of treatment and a less intensive phase including, but not limited to, orientation and work release.

1. During the intensive phase of treatment, each client shall participate in a minimum of thirty (30) hours of planned, structured, therapeutic activity per week.

2. During the less intensive phase of treatment, each client shall participate in a minimum of ten (10) hours of planned, structured, therapeutic activity per week;

(K) Individual counseling shall be provided to each person as follows:

1. Programs with an expected length of stay of six (6) months or less shall provide at least two (2) one-hour sessions per month; and

2. Programs with an expected length of stay of more than six (6) months shall provide at least one (1) one-hour session per month;

(L) Each client shall attend a minimum of two (2) one-hour group counseling sessions per week;

(M) A discharge summary shall be completed and entered in the client's record within fifteen (15) days of discharge or transfer from the program;

(N) For each group session, a group log shall document the type of service, summary of the service, date, actual beginning and ending time, clients' attendance and the signature and title of the staff member providing the service. Group activities may be documented in the client record on a prepared schedule, validated by the initials of the service provider; and

(O) There shall be written policies and procedures to assure the quality of client records.

1. Reviews shall include all applicable forms and documents.

2. Reviews shall include appropriate clinical content of the following documentation: comprehensive assessment; individualized treatment plan and updates; progress notes; continuing recovery plans; and discharge summaries.

3. Random reviews shall be conducted on a quarterly basis.

4. The agency shall maintain a record of files reviewed and include recommendations, corrective actions, and the status of previously identified problems.

5. Files shall reflect date of review and title and signature of person conducting the review.

(8) Client Rights, Responsibilities and Grievances. Requirements under 9 CSR 10-7.020 Client Rights, Responsibilities and Grievances are included by reference and are adapted for institutional corrections treatment programs as follows:

(A) Each individual shall be entitled to these rights, privileges and procedures except where they conflict with rules or official policy governing the rights and privileges of individuals in the custody of the Department of Corrections;

(B) Any deviations from the rights, privileges and procedures defined in 9 CSR 10-7.020 which are necessary for all individuals shall be identified in the organization's policy and procedures manual, approved by its governing authority, and justified in its application for certification;

(C) The following rights enumerated under section 9 CSR 10-7.020(3) may be waived:

1. To receive services in the least restrictive environment;
2. To consult with a private, licensed practitioner at one's own expense;
3. To be paid for work unrelated to treatment, except that the individual may be expected to perform limited tasks and chores within the program that are designed to promote personal involvement and responsibility, skill building or peer support. Any tasks and chores beyond routine care and cleaning of activity or bedroom areas within the program must be directly related to recovery and treatment plan goals developed with the individual;

(D) The right to see one's own records applies only to treatment records;

(E) The following rights enumerated under section 9 CSR 10-7.020(4) may be waived:

1. To wear one's own clothes and keep and use one's own personal possessions;
2. To keep and be allowed to spend a reasonable amount of one's own funds;
3. To have reasonable access to a telephone to make and to receive confidential calls;
4. To be free from seclusion and restraint;
5. To receive visitors of one's own choosing at reasonable hours; and
6. To communicate by sealed mail with individuals outside the facility;

(F) The right to use the telephone and receive visitors is subject to the policies of the Department of Corrections; and

(G) The organization shall ensure that all individuals have the same legal rights and responsibilities as any other citizen, unless otherwise limited by law or Department of Corrections policy.

(9) Behavior Management. Requirements related to behavior management under 9 CSR 10-7.060 are not applicable to institutional corrections treatment programs.

(10) Medications. Requirements under 9 CSR 10-7.070 Medications are included by reference, except that medication requirements do not apply to an institutional dispensary or other medical unit of the facility where services are provided under contractual agreement.

(11) Dietary Service. Requirements under 9 CSR 10-7.070 Dietary Service are included by reference with the following modification for institutional corrections treatment programs.

(A) An institutional corrections treatment program shall include, as part of its application for certification, evidence that its dietary staff, services and facility comply with applicable requirements established by the Department of Corrections.

(B) If this documentation is provided, the institutional corrections treatment program shall be considered in compliance with 9 CSR 10-7.070 Dietary Service.

(12) Personnel. Requirements under 9 CSR 10-7.100 Personnel are included by reference with additional requirements as follows:

(A) The institutional corrections treatment programs shall have a written plan for professional growth that includes cross training in treatment and corrections, and multi-cultural diversity;

(B) Correctional staff that have direct client contact shall be cross trained in treatment issues and exhibit a philosophy that treatment works; and

(C) Treatment staff shall be cross trained in correction issues and understand that custody and protection of the public, staff and offenders are the first priority of security.

(13) Physical Plant and Safety. This section modifies the requirements under 9 CSR 10-7.110 Physical Plant and Safety for institutional corrections treatment programs. Physical plant and safety standards, which would otherwise be in conflict with Department of Corrections policies and procedures, shall be waived.

(A) The program shall comply with Department of Corrections requirements regarding safety including fire safety and emergency preparedness, security, cleanliness and comfort.

(B) The institutional corrections treatment program shall, upon application for certification, provide evidence that the program meets applicable Department of Corrections requirements in these areas. Where such evidence is provided, the agency shall be considered to be in compliance with environmental standards.

(C) The design and structure of the institutional setting shall be sufficient to accommodate staff, clients and functions of the program.

AUTHORITY: sections 313.842, 630.050 and 630.655, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 313.842, RSMo 1991, amended 1996, 2000; 630.050, RSMo 1980, amended 1993, 1995; and 630.655, RSMo 1980.*

9 CSR 30-3.190 Specialized Program for Women and Children

PURPOSE: This rule establishes requirements relative to specialized substance abuse programs for women and children.

(1) Eligibility Criteria. The program shall provide treatment, rehabilitation, and other supports solely to women and their children. Services may be offered on a residential or outpatient basis, in accordance with admission and eligibility criteria for those programs and settings specified elsewhere in these rules.

(A) Priority shall be given to women who are pregnant, postpartum, or have children in their physical care and custody. Postpartum shall be defined as up to six (6) months after delivery.

1. The program shall engage in all activities necessary to ensure the actual admission of and services to those women who meet priority criteria.

2. Adolescents who meet priority criteria shall be admitted if, in the staff's clinical judgment, the adolescent can appropriately participate in and benefit from the services and milieu offered.

(B) Programs designated for women and children will ensure that treatment occurs in the context of a family systems model. Each program will provide therapeutic activities designed for the benefit of children. Thus, it is important that children should accompany their mother, unless contraindicated by medical, educational, family, legal or other reasons which are documented in the client's record.

(2) Therapeutic Issues Relevant to Women. The program shall address therapeutic issues relevant to women and shall address their specific needs.

(A) Therapeutic issues relevant to women shall include, but are not limited to, parenting, relationship issues, self-esteem/self-identification, domestic violence, sexuality, health, and spirituality.

(B) Residential treatment and community-based primary treatment shall include planned, supervised activities to promote parent-child bonding.

(3) Supervision of Children. Children shall be supervised at all times.

(A) The parent/guardian should be responsible for providing supervision when the child is not attending day care or participating in other scheduled program activities.

(B) Program staff shall assist the parent in providing age-appropriate activities, training and guidance.

(4) Availability of Day Care and Staffing Patterns. The program shall ensure that child care/day care is available for children while the mother participates in treatment and rehabilitation services.

(A) The program shall obtain licensure as a day care center, unless an exception is granted by the department.

(B) If an exception is granted, the program shall nevertheless meet any licensure requirements that the department determines to be appropriate or applicable to the program. The program shall—

1. Employ a full-time staff person to assume responsibility for day care services. The person shall be qualified by having a minimum of a bachelor's degree in early childhood education or closely related field;

2. Maintain a staff-to-child ratio at the following age-related levels:

A. Birth through two (2) years. Groups composed of mixed ages through two (2) years shall have no less than one (1) adult to four (4) children, with no more than eight (8) children in a group;

B. Age two (2) years. Groups composed solely of two (2)-year-olds shall have no less than one (1) adult to eight (8) children, with no more than sixteen (16) children in a group;

C. Ages three through four (3–4) years. Groups composed solely of three (3) and four (4)-year-olds shall have no less than one (1) adult to ten (10) children;

D. Ages five (5) and up. Groups composed solely of five (5)-year-olds and older shall have no less than one (1) adult to every sixteen (16) children; and

E. Mixed age groups two (2) years and up. Groups composed of mixed ages of children two (2) years of age and older shall have no less than one (1) adult to ten (10) children with a maximum of four (4) two (2)-year-olds. When there are more than four (4) two (2)-year-olds in a mixed group, there shall be no less than one (1) adult to eight (8) children;

3. If a center has an attendance of more than fifty (50) children, the center director or individual in charge shall not be included in staff/child ratios except during naptime or on an emergency substitute basis;

4. If a center has an attendance of more than thirty (30) children at lunch or dinner time, staff shall be provided for meal preparation, serving and cleanup. The staff shall not be included in staff/child ratios during this time; and

5. Individuals employed for clerical, housekeeping, cleaning and maintenance shall not be included in staff/child ratios while performing those duties.

(C) Day care shall not be funded by the division for children who are thirteen (13) or older, unless there has been specific authorization based on clinical utilization review.

(5) Therapeutic Issues Relevant to Children. The program shall address therapeutic issues relevant to children and shall address their specific needs. Age-appropriate activities, training and guidance shall be offered to meet the following goals:

(A) To build self-esteem;

(B) To learn to identify and express feelings;

(C) To build positive family relationships;

(D) To develop decision-making skills;

(E) To understand chemical dependency and its effects on the family;

(F) To learn and practice nonviolent ways to resolve conflict;

(G) To learn safety practices such as sexual abuse prevention; and

(H) To address developmental needs.

(6) Education for Children. The program shall assist the parent/guardian as necessary to ensure educational opportunities for school age children in accordance with the requirements of the

Department of Elementary and Secondary Education.

(7) Documenting Services to Children. The program shall document any services provided to children, including day care and community support.

(A) The record shall document the child's developmental, physical, emotional, social, educational, and family background and current status.

(B) To determine the need for a child to receive services beyond day care and community support, a trained staff member shall complete an initial screening instrument approved by the department. The screening shall include an interview with at least one (1) parent and the child, whenever appropriate.

(C) If indicated by the screening, a qualified staff member will complete an assessment instrument approved by the department. The assessment will determine the appropriateness of therapeutic services and provide information to guide development of an individual plan. The assessment must be completed before a child receives any services beyond day care and community support.

(D) The child's individual plan and consent for treatment must be signed by the legal guardian.

(8) Staff Training. Service delivery staff and program administration shall demonstrate expertise in addressing the needs of women and children. All service delivery staff shall receive periodic training regarding therapeutic issues relevant to women and children.

(9) Safety and Health. The program shall maintain a safe, healthy environment which is responsive to the physical and medical needs of women and children.

(A) A registered nurse (one (1) full-time equivalent) shall be available within the program.

(B) At least one (1) staff member shall be on duty at all times who has current training in first aid and cardiopulmonary resuscitation for infants, children and adults.

(C) The program shall demonstrate effective working relationship(s) with a physician, hospital, and/or clinic to provide medical care for women, including pregnant and postpartum women, and their children.

(D) The program shall ensure an evaluation of medical need for each woman and child and shall ensure that each woman and child is medically stable to safely and adequately participate in services. For women, the evaluation of medical need shall include:

1. Current physical status, including vital signs; and
2. Any symptoms of intoxication, impairment or withdrawal.

(E) The program shall ensure that recommendations by a physician or licensed health care provider are implemented regarding medical, physical and nutritional needs.

(F) If a specialized program for women and children provides detoxification services, it shall comply with applicable standards under 9 CSR 30-3.120 Detoxification. A specialized program for women and children shall not be required to accept applications for ninety-six (96)-hour civil detention of intoxicated persons due to the presence of children within the facility.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.192 Specialized Program for Adolescents

PURPOSE: This rule establishes requirements relative to specialized substance abuse programs for adolescents.

(1) Age Criteria for Adolescents. The program shall provide treatment, rehabilitation, and other services solely to clients between the ages of twelve through seventeen (12–17) years inclusive and their families. Exceptions to these age requirements may be authorized through clinical utilization review for those individuals in whom there is justification and documentation of behavior and experience appropriate for the services available.

(2) Other Eligibility Criteria. The level of care and treatment setting for adolescent services shall be based on problem severity ratings in the following domains:

(A) Substance Abuse Patterns/Withdrawal Risk. This includes factors such as recent use patterns (substances used, frequency, amount, method of administration), consequences of use, progression, tolerance, and withdrawal risk;

(B) Physical Health. This includes physical health conditions that require ongoing care and that may be a factor in treatment planning;

(C) Emotional/Behavioral Functioning. This includes factors such as suicidal ideation or plans, aggressiveness, severe conflict with others, recent running away from home; co-occurring psychiatric disorders, and need for continuous supervision;

(D) Acceptance/Resistance. This includes factors such as blaming others, willingness to acknowledge problems, and attempts to stop or cut back substance use;

(E) Abstinence Potential. This includes factors such as substance use in the past thirty (30) days, longest period of abstinence in the past six (6) months, impulsiveness, general ability to follow through with appointments and responsibilities;

(F) Recovery Environment. This includes factors such as non-using friends, involvement in non-using activities, school attendance and performance, geographic access to treatment services, and involvement of other persons or agencies to support recovery; and

(G) Family/Caregiver Functioning. This includes factors such as appropriateness of rules and consequences, availability of supervision, presence of others in the household with active substance abuse, emotional and psychiatric functioning of caregivers, ability and willingness to participate in the treatment and recovery process.

(3) Treatment Principles and Therapeutic Issues Relevant to Adolescents. The program shall address therapeutic issues relevant to adolescents and shall address their specific needs. The following principles and methods shall be reflected in services delivered to adolescents:

(A) Adolescents are best treated in settings that are programmatically and physically separate from treatment services for adults;

(B) Services shall maintain youth in the family and community setting, whenever clinically feasible;

(C) Services shall support the family and engage the family in a recovery and change process, whenever appropriate. If the parent(s) are not an available and appropriate resource, program staff shall assist in developing alternate social and family support systems for the adolescent;

(D) Services to the family shall be directed to understanding and supporting the youth's recovery process, identifying and intervening with parental substance abuse problems, improving parenting skills and communication skills within the family, and assisting the family in improving its level of functioning;

(E) A cooperative team approach shall be utilized in order to provide a consistent environment and therapeutic milieu;

(F) Cooperation with other youth-serving agencies shall be demonstrated in order to ensure that needs of youth in treatment are met and that services are coordinated. Coordination of service needs are critical with youth due to their involvement with other community agencies and reliance on the family, as well as the fact that substance abuse affects multiple life areas; and

(G) Service delivery shall address—

1. Recovery issues such as peer relationships, use of leisure time, and abuse and neglect;

2. Skill development such as decision-making and study skills; and

3. Information and education regarding adolescent developmental issues and sexuality.

(4) Living Arrangements. Adolescents may be served from a variety of living arrangements including, but not limited to, the following:

(A) Home of the parent/guardian;

(B) Foster home;

(C) Residential settings operated by the program;

(D) Juvenile detention;

(E) Other supervised living arrangements; or

(F) Independent living.

(5) Family Involvement. Each adolescent's living arrangement and family situation shall be reviewed by program staff in order to identify needs and to develop treatment goals and recovery supports for the adolescent and the family.

(A) This review shall be done by a family therapist.

(B) Refusal by the family for an in-home assessment shall not constitute automatic denial of treatment services for adolescents.

(C) The program shall actively involve family members in the treatment process, unless contraindicated for legal or clinical reasons which are documented in the client record.

(D) Staff shall orient the parent or legal guardian regarding—

1. Treatment philosophy and design;

2. Discipline and any behavioral management techniques used by the program;

3. Availability of staff to conduct home-based treatment and community support services;

4. Emergency medical procedures; and

5. Expectations about ongoing family participation.

(E) Staff shall seek family participation in treatment planning, service delivery and continuing recovery planning.

1. Services may include family participation in educational and counseling sessions.

2. Family participation in treatment planning shall be documented in the client record. In the event that the family does not participate, then staff shall document efforts to involve the family and reasons why the family did not participate.

(6) Educational and Vocational Opportunities. The program shall assist the adolescent and parent/guardian as necessary to ensure educational and/or vocational opportunities during treatment.

(7) Privilege System. Any system used by the program to modify behavior by requiring certain behaviors to earn privileges or restricting privileges (that is, step-down program) for failure to comply with requirements shall be defined in writing, stated in behavioral terms to the extent possible, and applied consistently to all clients.

(8) Safety and Health. The program shall maintain a safe, healthy environment which is responsive to the physical and medical needs of adolescents.

(A) Adolescents shall be prohibited from smoking on the premises, grounds and any off-site program functions.

(B) For adolescents receiving residential support, the program must provide or arrange for a history and physical examination performed by a physician licensed in Missouri or a nurse practitioner licensed and authorized to title and practice as an advanced practice nurse pursuant to 335.016, RSMo and who is engaged in a written collaborative practice arrangement as defined by law.

Registered nurses may still conduct initial health screenings upon admission to a residential support setting, but this screening does not satisfy the requirement for a history and physical examination as defined above.

(C) The program shall demonstrate effective working relationship(s) with a physician, hospital, and/or clinic to provide medical care for adolescents.

(9) Staff Training and Supervision. Service delivery staff shall—

(A) Have training and demonstrate expertise regarding the treatment of both substance abuse and other disorders related to adolescents; and

(B) Receive clinical supervision by an appropriately licensed, certified, or otherwise credentialed person with experience in the treatment of adolescents.

(10) Structured Activities Available to Adolescents Living in a Residential Setting. In addition to treatment services, adolescents living in a residential setting operated by the program shall have their awake time structured in activities, such as academic education, completing assignments, attendance at self-help groups, family visits and positive leisure.

(11) Staffing Patterns in a Residential Facility. The following minimum client to staff ratios shall be maintained at all times adolescents are present in a residential facility—

(A) At a facility with six (6) residents or less, one (1) staff member must be providing supervision of clients during program hours and also during designated client sleeping hours;

(B) At a facility with seven through twelve (7–12) residents, two (2) staff members must be providing supervision of clients during program hours and also during designated client sleeping hours;

(C) At a facility with thirteen through sixteen (13–16) residents, three (3) staff members must be providing supervision of clients during program hours, with a required ratio of two (2) staff during designated client sleeping hours; and

(D) At a foster home funded by the department, a foster parent must provide or arrange for appropriate supervision of the adolescent(s) at all times.

(12) If the adolescent residential support facility serves a coed population, the staffing pattern shall include at least one (1) female and at least one (1) male staff member any time residents are present. If residential support is provided for girls only, a female staff member must be present at all times. If residential support is provided for boys only, a male staff member must be present at all times.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed April 15, 2002, effective Nov. 30, 2002. Amended: Filed July 29, 2002, effective March 30, 2003.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.201 Substance Abuse Traffic Offender Programs

PURPOSE: This rule identifies the Department of Mental Health as being responsible for the certification of Substance Abuse Traffic Offender Programs as mandated by state statute.

(1) Mission. The Missouri Substance Abuse Traffic Offender Programs (SATOP) is a statewide system of comprehensive, accessible, community-based education and treatment programs designed for individuals arrested for alcohol and drug-related driving offenses. The mission of SATOP is to—

(A) Inform and educate these drivers as to the hazards and consequences of impaired driving;

(B) Promote safe and responsible decision making regarding driving;

(C) Motivate for personal change and growth; and

(D) Contribute to public health and safety in Missouri.

(2) Program Functions. Substance Abuse Traffic Offender Programs shall provide or arrange for assessment screening, education and rehabilitation.

(3) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization providing SATOP to demonstrate achievement of the program's mission and functions. Indicators can include, but are not limited to the following:

(A) Characteristics of persons participating in SATOP such as blood alcohol content (BAC) level, type of offenses, prior drinking and driving arrests, prior SATOP participation, etc;

(B) Consistent use of screening criteria including the rate at which persons are assigned to the various types of education, intervention and treatment programs;

(C) Rate at which persons successfully complete SATOP and the various types of programs available;

(D) Reductions in drinking and driving among those who complete SATOP; and

(E) Consumer satisfaction and feedback.

(4) Types of Programs. The department shall recognize and certify the following types of Substance Abuse Traffic Offender Programs:

(A) Adolescent Diversion Education Programs (ADEP) which provide offender education to those persons coming under the purview of sections 577.500, 577.525, RSMo and to those under the age of twenty-one (21) coming under the purview of sections 302.510, 302.540 and 577.049, RSMo;

(B) Youth Clinical Intervention Programs (YCIP) which provide intervention, education, and long-term counseling for offenders who are identified through an assessment screening as having alcohol and/or other substance abuse problems and who are under the age of twenty-one (21). A Youth Clinical Intervention Program shall provide twenty-five (25) hours of therapeutic activity for each offender, including ten (10) hours designed to address the issue of drinking and driving;

(C) Offender Management Units (OMU) which provide assessment screening including an individualized interview, recommendation and referral for further services for those coming under the purview of applicable sections of Chapters 302 and 577, RSMo, or by order of the court;

(D) Offender Education Programs (OEP) which provide basic offender education over the course of ten (10) hours for lower risk first offenders to assist them in understanding the choices they made that led to their arrest and the resulting consequences. All persons completing this course shall develop a personal plan of action to assist them in preventing impaired driving behavior;

(E) Weekend Intervention Programs (WIP) which provide specialized intervention and education for repeat offenders or offenders showing signs and symptoms of a significant substance abuse problem. A Weekend Intervention Program shall provide a minimum of twenty (20) program hours conducted over a forty-eight (48)-hour weekend;

(F) Clinical Intervention Programs (CIP) which provide intervention, education, and long-term counseling for offenders who are identified through the assessment screening process as having alcohol and/or other substance abuse problems and who are not eligible for traditional residential treatment or traditional intensive outpatient services. A Clinical Intervention Program shall provide fifty (50) hours of therapeutic activity for each offender including ten (10) hours designed to address the issue of drinking and driving; and

(G) SATOP Training Programs which provide regional training to persons seeking to be recognized and certified by the department as a qualified instructor, qualified substance abuse professional, or administrator within SATOP.

(5) Requirements for Program Certification. SATOP programs shall comply with those rules and standards listed under 9 CSR 30-3.032 Certification of Alcohol and Drug Abuse Programs.

(A) Rules under 9 CSR 10-7.120 Physical Plant and Safety shall be applicable based on the type of services provided by the program and whether services are offered to individuals and groups at the program site. In addition:

1. The program must be located in an office, clinic or other professional setting;

2. Assessment screenings must be located in a setting which provides space for private, one-on-one interviews and ensures confidentiality. With the department's written approval, assessment screenings may be conducted at other locations on a limited basis, if confidentiality is assured and the individual agrees to a screening at the alternate site.

(B) Clinical Intervention Programs (CIP) and Youth Clinical Intervention Programs (YCIP) shall meet standards under 9 CSR 30-3.130 Outpatient Treatment and fulfill contract requirements.

1. A YCIP shall also meet standards under 9 CSR 30-3.192 Specialized Program for Adolescents.

2. The waiver of standards listed in subsection (5) (C) of this rule shall not apply to CIP and YCIP programs.

(C) The following rules and standards shall be waived for other types of SATOP programs, unless the department determines that a specific requirement is applicable due to the unique circumstances and service delivery methods of a program:

1. 9 CSR 10-7.010 Treatment Principles and Outcomes;

2. 9 CSR 10-7.030 Service Delivery Process and Documentation;

3. 9 CSR 10-7.060 Behavior Management;

4. 9 CSR 10-7.070 Medications;

5. 9 CSR 10-7.080 Dietary Services;

6. 9 CSR 30-3.100 Service Delivery Process and Documentation (ADA); and

7. 9 CSR 30-3.110 Service Definitions and Staff Qualifications (ADA).

(6) Other Requirements. In addition to the requirements listed under 9 CSR 30-3.032 Certification of Alcohol and Drug Abuse Programs, the department shall use the following criteria in certifying Substance Abuse Traffic Offender Programs:

(A) The department reserves the right to limit the issuance of certification in certain venue areas when it cannot be determined a need exists for the service in that venue and/or when it cannot be determined the proposed service will serve the best interest of SATOP clients in that venue.

1. Determination of need shall be at the department's sole discretion as the designated state authority responsible for SATOP certification.

2. The determination of need shall be based on applicable data, such as the number of DWI arrests within the proposed service area and the number of currently certified SATOP agencies within the proposed service area.

(B) The department must approve any new program site prior to the delivery of SATOP services at the site. The program must submit photographs and a floor plan indicating accessibility compliance for the proposed sites.

(C) The department reserves the right to deny certification to any SATOP program that does not provide a minimum of services to at least fifty (50) persons per year.

(7) Rehabilitation Programs Recognized for SATOP. When the assessment screening indicates the individual's need for treatment and rehabilitation, arrangements should be made for the person to participate in such services.

(A) The department shall recognize the following types of treatment and rehabilitation programs for alcohol and drug-related traffic offenders:

1. Certified Alcohol and/or Drug Treatment and Rehabilitation Programs;

2. Clinical Intervention Programs (CIP); and

3. Youth Clinical Intervention Programs (YCIP).

(B) Clinical Intervention Programs (CIP) and Youth Clinical Intervention Programs (YCIP) must—

1. Meet requirements under 9 CSR 30-3.130 Outpatient Treatment; and

2. Remain in compliance with their contract.

(8) Compliance. Failure to adhere to the stipulations, conditions, and requirements set forth in this rule shall be considered cause for revocation or denial of program certification.

AUTHORITY: sections 302.540, 577.001, 577.049, 577.520, 577.525, 630.050, 630.053, 630.655 and 631.010, RSMo 2000. This rule was originally filed as 9 CSR 30-3.700. Emergency rule filed April 22, 1983, effective May 2, 1983, expired Aug. 11, 1983. Original rule filed May 13, 1983, effective Sept. 11, 1983. Amended: Filed May 6, 1985, effective Sept. 1, 1985. Rescinded and readopted: Filed Nov. 2, 1987, effective May 15, 1988. Amended: Filed Sept. 5, 1990, effective Feb. 14, 1991. Emergency amendment filed May 3, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency amendment filed Oct. 17, 1994, effective Oct. 28, 1994, expired Feb. 24, 1995. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Moved to 9 CSR 30-3.201 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 302.540, RSMo 1983, amended 1984, 1993, 1996; 577.001, RSMo 1982, amended 1986, 1996; 577.049, RSMo 1982, amended 1993, 1996; 577.520, RSMo 1987, amended 1991, 1993, 1996; 577.525, RSMo 1987, amended 1991, 1996; 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-2.202 SATOP Administration and Service Documentation

PURPOSE: This rule establishes administrative procedures and practices in the operation of Substance Abuse Traffic Offender Programs.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) Program Administrator. An administrator shall be identified for the program.

(A) The administrator shall be the individual ultimately responsible for the proper operation of the program, regardless of whether the program is operated by a probation department, another agency, or organization.

(B) The administrator should be knowledgeable in the areas of fiscal management, program operation, course-scheduling and court referral procedures.

(C) All administrators making application for program certification must meet the educational and experiential requirements as either a qualified instructor or a qualified professional and must have attended approved Substance Abuse Traffic Offender Program (SATOP) administrator training.

(2) Access. The program shall be accessible to the public by maintaining reasonable business hours and ready telephone access.

(3) Admission. All persons referred by a court or probation and parole shall be accepted for admission. Other individuals may be accepted upon the approval of the administrator.

(4) Conflict of Interest. An agency which operates probation services, court supervision programs, or non-certified counseling programs must keep these functions separate and distinct from the SATOP program.

(A) The agency must clearly communicate to clients that completion or the failure to complete these programs will not affect their SATOP outcome.

(B) Completion of a SATOP at the agency shall not be made a condition of supervision or probation either directly or by inference.

(5) Notice to Clients. Written notice shall be provided to clients regarding the cost of the program, dates, times, location and requirements for successful program completion.

(6) Attendance Records. Attendance records shall be maintained for each session.

(7) Receipts. Receipts shall be issued for all client money received.

(8) Behavioral Expectations. The agency shall deny access to any program by a person who arrives under the influence of mood-altering substances and shall remove from any program any person who detracts from the program because of uncooperative behavior.

(A) Program staff shall have the authority to deny access to and remove a client from a program. Testing of blood, breath or urine shall not be required or used in and education program.

(B) A written report of the incident shall be made by the program staff and reviewed by the administrator who shall make a final disposition.

(C) A person who has justifiably been denied access to or removed from a program shall not be considered to have satisfactorily completed the program.

(D) A person who has justifiably been denied access to or removed from a program shall not be readmitted to that level of service without written approval by the department.

(9) Assessment Recommendation. The program shall have written policies and procedures which stipulate the methods of individualized assessment and the conditions under which referrals are made for further services. The written policies and procedures must follow the guidelines outlined in the current edition of the *Safe and Sober Screening Manual* and incorporated herein by reference. The written policies and procedures shall address the client's right to a second opinion and procedures for judicial review, if necessary.

(A) An assessment recommendation shall be delivered in writing to the person with written notice that the person is entitled to have this recommendation reviewed by a court pursuant to sections 302.304 and 302.540, RSMo.

(B) A person who objects to the recommendation may file a motion in the associate division of the circuit court, on a printed form provided by the state courts administrator, to have the court hear and determine such motion.

(10) Resources and Referrals. A current resource directory of area self-help groups and substance abuse services shall be maintained.

(A) A person who receives a recommendation for further services shall be given a list of area agencies which includes all certified programs that offer the recommended level of service.

(B) The person shall sign a statement acknowledging receipt of the list. The statement shall also indicate that he or she is not required to obtain recommended services from the same agency that has conducted the individualized assessment.

(11) Consumer Evaluation and Satisfaction. All persons participating in a SATOP program shall be asked to complete a course evaluation.

(A) Participants may be encouraged, but not required, to sign the evaluation form.

(B) Evaluations shall be retained by the program for two (2) years or until completion of the next site survey, whichever is longer.

(12) Data Collection. The program shall cooperate with all SATOP quality assurance and data collection requirements regarding the program operation, DWI offender demographics, or other data collection that may be required by the department. Failure to submit requested information in a timely fashion may result in administrative sanction or revocation of certification.

(13) Master List of Clients. An agency shall keep a master list of all clients who have been admitted or enrolled in its SATOP program(s) to include: name, dates of attendance, program type and whether the client successfully completed the program.

(14) Client Records. An organized record shall be maintained on each person who participates in a SATOP program.

(A) Records shall be stored in a manner to protect confidentiality.

(B) Records shall be retained for at least two (2) years or until completion of the next site survey, whichever is longer. However, if the agency is contracted with the department, the contract requirements for retaining records shall prevail.

(15) Content of Client Records. Each client record shall include:

(A) Dates of attendance;

(B) Demographic information sufficient to complete the division's annual report form;

(C) Scored pretests and posttests measuring knowledge gain and attitude change;

(D) Proper, signed release of information forms;

(E) Department of Revenue driving record check;

(F) Documentation of an individualized assessment screening, where required. The documentation shall include the name of the qualified professional, date, amount of time spent, summary of the screening instrument results which includes a substance use history, summary of findings, recommendation and student's response to the recommendation;

(G) Where applicable, signed acknowledgment of receiving an assessment screening recommendation, a list of referral resources, and notice that any additional services may be received from a different provider;

(H) Copy of the SATOP Offender Assignment, Report of Offender Compliance, and the SATOP Completion Certificate; and

(I) Program evaluation completed by the client.

(16) Additional Client Record Requirements for ADEP. For Adolescent Diversion Education Program (ADEP) clients who are under the age of eighteen (18) and are not emancipated, there shall be documentation showing—

(A) Efforts to involve the parent or guardian in the program;

(B) Results of the efforts, that is, whether the parent participated and the extent of participation; and

(C) Where applicable, the parent or guardian's view of substance use patterns and possible effects on family, social, legal, emotional, physical, financial, educational and vocational functioning.

(17) Compliance. Failure to adhere to the stipulations, conditions, and the requirements set forth in this rule shall be considered cause for revocation or denial of program certification.

AUTHORITY: sections 302.304, 302.540, 577.001, 577.049, 577.520, 577.525, 630.050, 630.053, 630.655 and 631.010, RSMo 2000. This rule was originally filed as 9 CSR 30-3.730. Original rule filed Nov. 2, 1987, effective May 15, 1988. Emergency amendment filed May 3, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency amendment filed Oct. 17, 1994, effective Oct. 28, 1994, expired Feb. 24, 1995. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Moved to 9 CSR 30-2.202 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 302.304, RSMo 1961, amended 1972, 1973, 1972, 1973, 1979, 1983, 1984, 1989, 1991, 1996;*

302.540, RSMo 1983, amended 1984, 1993, 1996; 577.049, RSMo 1982, amended 1993, 1996; 577.520, RSMo 1987, amended 1991, 1993, 1996; 577.525, RSMo 1987, amended 1991, 1996; 630.050, RSMo 1980, amended 1993, 1995; 630.053, RSMo 1993, amended 1995, 1996; 630.655, RSMo 1980; and 631.010, RSMo 1980.

9 CSR 30-3.204 SATOP Personnel

PURPOSE: This rule describes the personnel policies, staff qualifications and training requirements in Substance Abuse Traffic Offender Programs and establishes specific policies and procedures for the revocation or suspension of certified personnel.

(1) Qualifications of Staff. The program shall have qualified staff.

(A) Assessments shall be done by qualified substance abuse professionals.

(B) Educational activities shall be done by qualified substance abuse professionals or by qualified instructors.

(C) A qualified instructor is a graduate of an accredited college or university with a bachelor's degree in counseling, criminal justice, education, psychology, social work or closely related field or a person designated as a Registered Alcohol and Substance Abuse Counselor (RASACII) by the Missouri Substance Abuse Counselors Certification Board, Inc. who is knowledgeable about substance abuse, as evidenced by either—

1. Nine (9) semester hours directly related to substance abuse;

2. One hundred forty-four (144) contact hours of continuing education directly related to substance abuse; or

3. One (1) year of full-time paid employment experience in the prevention, treatment or rehabilitation of substance abuse. Applicability of full-time experience shall be defined in the SATOP *Personnel Training and Certification Information Guide*.

(D) Staff who conduct education and assessment must—

1. Not have had a suspension or revocation of their drivers' licenses within the preceding two (2) years;

2. Not have received a citation or have been charged with any state or municipal alcohol- or drug-related offense within the preceding two (2) years, except when found not guilty in a court of competent jurisdiction;

3. Not have allowed the use of alcohol or other drugs to interfere with the conduct of their SATOP duties;

4. Successfully complete SATOP training offered or approved by the division;

5. Meet criminal record review requirements specified in 9 CSR 10-5.190; and

6. Be certified by the division prior to their employment as meeting requirements as a qualified instructor or qualified substance abuse professional.

(2) Certification of Staff. Individuals certified by the division shall continue to meet all applicable standards and requirements as a condition of their certification.

(A) The division may issue certification for a maximum of three (3) years.

(B) Renewal of certification may be obtained by submitting a satisfactorily completed application for certification and verification of a total of fifteen (15) hours of continuing education or training in the substance abuse field during the prior certification period. Continuing education or training must address prevention, education, or specific counseling techniques directly related to the drinking driver or persons with substance abuse problems. A sixty dollar ($60)-renewal fee must accompany the renewal application.

(C) Any administrator of a certified education program or related rehabilitation program and any individual certified by the division have the duty to report the suspected failure of any individual to meet applicable standards and requirements.

(D) Complaints or allegations against individuals working in SATOP programs that the division may investigate include, but are not limited to:

1. Failure to meet personnel requirements under this rule;

2. Violations of client rights under 9 CSR 30-3.202;

3. Fraudulent or false reporting to the division, Department of Revenue, courts or other agency;

4. Performance of duties for which the individual is not certified;

5. Conviction, plea of guilty or suspended imposition of sentence for any felony or alcohol- or drug-related offense; and

6. Failure to cooperate in any investigation by the division.

(E) The division may reprimand, suspend or revoke the certification of any individual who fails to meet standards and requirements or who fails to report suspected violations of those standards and requirements.

(F) Suspension or revocation of certification may be appealed to the director of the Department of Mental Health within thirty (30) days after receiving notice of that action. The director shall conduct a hearing under procedures set out in Chapter 536, RSMo and issue findings of fact, conclusions of law and a decision which shall be final. If the suspension or revocation involves an allegation of client abuse or threat toward client safety, the department may make a determination to remove the staff person from direct client contact until the hearing is conducted and a disposition is made by the hearing officer.

(G) An individual whose certification has been revoked cannot reapply for certification until two (2) years have lapsed. The department's review of a future application will take into consideration the circumstances which led to revocation.

(3) SATOP Training. Staff with responsibilities for the administration, education or assessment functions of the program, or a combination of these, shall complete a training program offered or approved by the division. Staff may be employed in more than one (1) type of program, when training specific to each type has been completed and the staff member has been appropriately certified by the division.

(4) Guest Speakers and Volunteers. A program which utilizes guest speakers or volunteers shall have written policies and procedures for their recruitment, selection, training, supervision, dismissal and compensation, where applicable.

(A) The program shall maintain a roster of all approved guest speakers or volunteers and a description of the duties or tasks of each.

(B) Guest speakers shall not be considered instructors for the purpose of these rules.

(C) At no time shall a guest speaker or volunteer assume sole responsibility for the class.

(5) Compliance. Failure to adhere to stipulation, conditions, and requirements set forth in this rule shall be considered cause for revocation or denial of program certification.

(6) Form number MO 650-2934 is included herein. (Contact SATOP section for a copy of this form.)

AUTHORITY: sections 302.540, 577.001, 577.049, 577.520, 577.525, 630.050, 630.053, 630.655 and 631.010, RSMo 2000. This rule originally filed as 9 CSR 30-3.750. Original rule filed Nov. 2, 1987, effective May 15, 1988. Amended: Filed Oct. 2, 1990, effective Feb. 14, 1991. Emergency amendment filed May 3, 1994, effective July 1, 1994, expired Oct. 28, 1994. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Emergency amendment filed Oct. 17, 1994, effective Oct. 28, 1994, expired Feb. 24, 1995. Amended: Filed Oct. 17, 1994, effective April 30, 1995. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Moved to 9 CSR 30-3.204 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 302.540, RSMo 1983, amended 1984, 1993, 1996; 577.001, 577.049, RSMo 1982, amended 1993, 1996; 577.520, RSMo 1987, amended 1991, 1993, 1996; 577.525, RSMo 1987, amended 1991, 1996; and 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.206 SATOP Program Structure

PURPOSE: This rule establishes basic requirements and structure for Substance Abuse Traffic Offender Programs including the assessment screening and referral process.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) Program Functions. The program shall provide education, assessment screening and recommendation and, where appropriate, referral for further services.

(A) A program which provides assessment screening must also provide Offender Education Program (OEP) services.

(B) A person may request and attend any program operated by a different agency due to reasonable circumstances, such as distance, work schedule or other time factors.

(C) A separate amount paid by the client shall cover the assessment screening in addition to the cost of the program.

(2) Assessment Screening Process. All persons referred to Substance Abuse Traffic Offender Programs shall, prior to attending the education or rehabilitation program, receive an individualized assessment screening. The assessment screening is a process by which individuals are evaluated and recommended to the most appropriate level of service, either education or intervention or treatment, based on criteria established by the department and the clinical judgment of the qualified substance abuse professional. The assessment screening process shall include:

(A) Demographic data collection;

(B) A standardized screening instrument;

(C) A face-to-face individualized assessment screening interview;

(D) A legible hand-printed or typewritten screening report;

(E) Completion of the SATOP Offender Assignment form and, when requested, a narrative report to the court;

(F) Completion of the SATOP Completion Certificate to the court; and

(G) Minimal case coordination, when appropriate, to coordinate with the courts, probation and parole, or the Department of Revenue (DOR) to verify that education, rehabilitation and treatment recommendations have been completed.

(3) Components of Assessment Screening. The assessment screening by the certified program shall follow basic guidelines established by the department.

(A) All clients shall complete a valid and reliable screening instrument approved by the department to identify problem users. The screening instrument shall be standardized, consistent statewide, and interpreted by certified qualified substance abuse professionals who are properly supervised and trained in the use of the screening device.

(B) All clients shall have an individualized assessment screening interview conducted by a qualified substance abuse professional.

1. The individualized assessment screening shall determine the extent of the problem (or lack of a problem) and the level or type of rehabilitation or education services needed.

2. The assessment screening shall include, but not be limited to, a screening instrument summary including a substance use history, prior treatment history, summary of findings and a recommendation for either education or rehabilitation based on minimum referral guidelines.

3. The assessment screening report shall be accompanied by a DOR driving record and blood alcohol content (BAC) at time of arrest.

4. Collaborative information, such as previous treatment information and contacting significant others, may be obtained with proper authorization when appropriate.

5. The assessment screening shall be valid for six (6) months after the date of the initial screening for each alcohol- or drug-related traffic offense. The client must enroll in the assigned education or treatment program within six (6) months of the initial screening. The client's record may be closed after the six (6)-month period expires if the client has been notified by mail or by phone at least thirty (30) days prior to the closing. The notification must be documented in the client's record.

(4) Quality Recommendations. The program must develop assessment screening recommendations that are—

(A) Impartial and solely based on the needs of the offender and the welfare of society; and

(B) Never be used as a means of case finding for any particular rehabilitation program or as a marketing tool for any SATOP program.

(5) Referral Guidelines. The program must base the assessment screening recommendation for each person on the following referral guidelines:

(A) 1st Offense—OEP/ADEP education unless a more intense program is indicated by such factors as the blood alcohol content at the time of arrest, other alcohol/drug-related arrests, screening instrument recommendations, prior alcohol/drug treatment, or other occupational, relationship, or medical problems;

(B) 2nd offense—WIP unless a more intense program is indicated by such factors as the blood alcohol content at the time of arrest, other alcohol/drug-related arrests, screening instrument recommenddations, prior alcohol/drug treatment, or other occupational, relationship, or medical problems;

(C) 3rd offense—Clinical Intervention Program (CIP) unless a more intense program is indicated by such factors as the blood content at the time of arrest, other alcohol/drug-related arrests, screening instrument recommendations, prior alcohol/drug treatment, or occupational, relationship, or medical problems; and

(D) Multiple offenses with substance dependence—Residential treatment, day treatment or hospitalization. The treatment programming at this level must meet or exceed one hundred sixty (160) continuous hours per treatment episode. Offenders presenting for SATOP services having multiple alcohol- or drug-related traffic offenses with substance dependence may be court ordered to this level. Other SATOP clients may voluntarily admit themselves to treatment facilities provided they meet the appropriate admission criteria for substance dependence.

(E) Exceptions to these referral guidelines shall be permitted with departmental approval.

(F) Persons with a serious mental illness should have their mental health treatment needs addressed before completing any SATOP recommenddation. A mental health evaluation should be arranged for those clients identified with serious emotional or mental health problems during the SATOP assessment screening process. In order to promptly arrange the mental health evaluation, a SATOP conducting assessment screenings must maintain a formal affiliation agreement with either a certified or accredited mental health program or a licensed mental health practitioner. The client may resume SATOP participation upon stabilization of the problem as determined by the client's mental health provider.

(6) Assessment Screening Cost. The cost of the assessment screening, along with the sixty dollar ($60) supplemental fee, approved by the department shall be borne by the client and should not be excessively greater than relative costs indicate and shall include the costs for any case coordination functions necessary to—

(A) Monitor the client's progress in either education or a treatment and rehabilitation program; and/or

(B) Coordinate with the courts, or probation and parole.

(7) Notice of Program Assignment and Completion. The agency shall provide a SATOP Offender Assignment form, a SATOP Completion Certificate, and, where applicable, a Notice of Offender Compliance. The SATOP Completion Certificate shall be issued within one (1) week of receiving the Notice of Offender Compliance in the event the offender received the education course at another agency.

(A) A referring court or probation and parole office shall be sent a SATOP Offender Assignment form within one (1) week of the assessment screening and a SATOP Completion Certificate within one (1) week of program completion.

(B) A copy of the Notice of Offender Compliance form shall be sent to the Offender Management Unit within seven (7) days of an individual's participation in a program.

(C) The Department of Revenue shall be sent a SATOP Completion Certificate within one (1) week of program completion, when applicable.

(D) A copy of the SATOP Offender Assignment Form and the Notice of Offender Compliance Form shall be sent to the Department of Mental Health.

(E) A copy of the SATOP Offender Assignment form and the SATOP Completion Certificate shall be given to the individual and, where applicable, to the parent or guardian.

(8) Prior and Persistent Offenders. The department shall recognize three (3) types of treatment and rehabilitation programs for prior or persistent substance abuse traffic offenders.

(A) As used in SATOP rules, the terms prior and persistent offender shall mean—

1. Prior offender, a person who has a prior history of one (1) intoxication related traffic offense committed within five (5) years of the most recent offense for which the person is charged; and

2. Persistent offender, a person who has a prior history of three (3) or more intoxication related traffic offenses committed at different times within ten (10) years of a previous alcohol and/or drug related traffic offensive conviction.

(B) The following types of treatment and rehabilitation programs shall be recognized for prior or persistent offenders:

1. Clinical Intervention Program (CIP);

2. Youth Clinical Intervention Program (YCIP); and

3. Certified Alcohol and/or Drug Treatment and Rehabilitation Programs.

(9) Criteria for Successful Completion of Treatment. When the assessment screening process indicates and if the person is eligible, certified alcohol and drug treatment and rehabilitation programs may also provide services for prior and persistent offenders. In addition, such persons, including first offenders who complete certified rehabilitation programs after being charged or adjudicated for their DWI offense but prior to their OMU screening process, may substitute participation in these rehabilitation programs under certain conditions. In order to be recognized by SATOP as successfully completing treatment, the offender must have written verification from a certified treatment and rehabilitation program that he or she has—

(A) Participated as scheduled in treatment services on a residential and/or outpatient basis for a period of at least ninety (90) calendar days;

(B) Substantially achieved personal recovery goals; and

(C) Met any other program requirements for successful completion of treatment. Those persons presenting substance dependence with a history of multiple offenses must participate in one hundred sixty (160) hours of services during the treatment episode.

(10) Cost of Treatment. The client shall be responsible for all costs related to the completion of the treatment and rehabilitation programs referenced in or required by this rule.

(A) All clients shall be required to pay an initial base amount determined by the department before applying the department's Standard Means Test in accordance with 9 CSR 10-1.016.

(B) The client shall be responsible for all costs related to treatment which are not reimbursed through a third-party payer or the department's Standards Means Test process.

(C) Programs may develop long-term payment plans to reasonably assist the client in paying off any outstanding balances.

(11) Cost of SATOP. The cost for SATOP program shall be determined and approved by the department and shall be paid by the client and shall cover the cost of the program.

(12) Hours of Participation. The OEP/ADEP program shall provide at least ten (10) hours of education. The WIP program shall provide at least twenty (20) hours of education and intervention services.

(13) Curriculum Guides. The OEP program shall be conducted in accordance with the current edition of the *OEP Missouri Curriculum Guide*. The ADEP program shall be conducted in accordance with the current edition of the *ADEP Missouri Curriculum Guide*. The WIP program shall be conducted in accordance with the current edition of the *WIP Missouri Curriculum Guide*. A program must specifically request and obtain approval from the division before deviating in any manner from the content and methods in the applicable *Missouri Curriculum Guide* as incorporated herein by reference.

(14) Meals and Breaks. Ample time shall be provided for breaks and meals, where appropriate.

(A) No class shall continue for more than two (2) hours without a break.

(B) The time for breaks shall not be counted toward the required hours of education.

(C) Break time should not exceed more than five (5) minutes per classroom hour of education.

(D) Break time should not be used at the beginning or the end of the classroom session.

(15) Length of Educational Sessions. The OEP/ADEP education component shall be conducted in at least two (2) calendar days.

(A) No OEP/ADEP session shall last more than six (6) hours, not counting breaks.

(B) No session may begin before 8:00 a.m. or end after 11:00 p.m.

(16) Use of Instructional Aids. Instructional aids shall be utilized.

(A) Aids may include, but are not limited to, films, videotapes, worksheets and informational handouts.

(B) Films and videotapes shall not comprise more than twenty percent (20%) of the educational component. Audiovisual instructional aids should—

1. Produce a clear image when projected on a clear surface;

2. Utilize a television monitor at least twenty-five inches (25") in diameter;

3. Utilize high quality videotapes or films; and

4. Allow all participants to have an unobstructed view.

(17) Guest Speakers. Use of guest speakers shall not comprise more than twenty percent (20%) of the educational component.

(18) Maximum Number of Persons in Educational Sessions. Program size shall provide an opportunity for client participation.

(A) It shall be usual and customary practice for each OEP/ADEP educational session to have no more than thirty (30) clients in order to promote discussion and participation.

(B) Parents, guardians or significant others who may attend a session or part of a session are not included in the figure of thirty (30) clients.

(19) Criteria for Successful Completion of SATOP Programs. Successful completion requires that the client shall—

(A) Be free of the influence of mood-altering substances at every session;
(B) Attend all sessions on time;
(C) Attend sessions in their proper sequence unless the instructor approves an alternate sequence;
(D) Complete all assignments and cooperatively participate in all class activities;
(E) Pay all fees; and
(F) Complete and sign all required forms.

(20) WIP Requirements. In addition to the basic requirements for OEP/ADEP programs, WIP programs shall—
(A) Be conducted in accordance with the applicable *Missouri Curriculum Guide* for WIP;
(B) Be conducted in a supervised environment approved by the division during a forty-eight (48)-hour weekend;
(C) Provide a minimum of twenty (20) hours of education and intervention;
(D) Provide meals and appropriate sleeping arrangements.
1. Sleeping arrangements should not exceed four (4) persons per room. Waivers for sleeping arrangements may be granted in some instances for programs operated through correctional or detention facilities;
2. Agencies must provide documentation that individuals preparing or handling meals for the Weekend Intervention Program meet state, county, or city regulations related to the handling of food;
(E) Conduct small group breakout discussion and intervention sessions which shall be facilitated by at least one (1) qualified professional per twelve (12) clients. In the event two (2) professional staff co-facilitate a small group, one (1) of the staff may be a qualified instructor or an associate counselor if the group size does not exceed twenty-four (24) clients;
(F) Not exceed thirty (30) clients per staff member in large group education lectures and films;
(G) Conduct a medical screening on each participant using the DMH 8618 Non-Emergency Medical Evaluation Checklist; and
(H) Complete a comprehensive assessment on each participant including a legal, social, occupational, physical, psychological, financial, and alcohol/-drug problem assessment.

(21) WIP Drug Testing. WIP programs may use breath or urine testing when alcohol or other drug usage is suspected, but cannot otherwise be verified, during the course of the WIP weekend. A written report of the incident shall be made by the WIP staff and reviewed by the WIP program director that will make the final decision as to the client suitability for continuation in the program. Random breath or urine testing shall not be used.

(22) WIP Cost. The cost of the WIP program may be partially offset for some clients by the department, provided funds are available and the person is in need of assistance by meeting the eligibility criteria based on the department's Standard Means Test. These offenders shall be required to pay the basic cost of SATOP in addition to any partial offset towards the cost of the WIP program.

(23) Review and Approval of Costs. The cost for all SATOP programs approved by the department shall be periodically reviewed and adjusted, if necessary, based on the best interests of clients, society and the programs.

(24) Certification of SATOP Training Programs. The department shall certify regional training programs. A certified training program must:
(A) Provide all of the basic core functions of SATOP;
(B) Develop an individualized training plan for each person in training;
(C) Assign a trainer to each person in training;
(D) Provide the opportunity for direct program observation of each program activity by each person in training; and
(E) Maintain full compliance with certification standards.

(25) Training Content. Training shall include, but not be limited to, the following:
(A) Review of certification standards;
(B) Basic agency management;
(C) Characteristics of DWI offenders;
(D) Assessment procedures including the individualized interview and use of the screening instruments;
(E) The principles and techniques of classroom management;
(F) The principles and techniques of adult learning;
(G) Orientation to the appropriate curriculum guide;
(H) Review of the referral process and treatment resources;
(I) SATOP personnel requirements; and
(J) Professional ethics.

(26) Program Observation Required. Training shall include direct observation of a program conducted by a qualified trainer at a certified training program. The term qualified trainer is used to describe a qualified substance abuse professional who has experience in providing two hundred forty (240) hours of ADEP, OEP or WIP.

(27) Written Examination. Certified staff shall complete a written examination and demonstrate the knowledge necessary to conduct the Alcohol and Drug Education Program (ADEP) or the appropriate Substance Abuse Traffic Offender Program (SATOP).

(28) Cost of Training. The cost of training shall be determined and approved by the department. For each trainee who successfully completes the applicable training requirements, including payment of training cost, the training program shall notify the department within ten (10) days of the successful completion.

(29) Availability of Training. Training must be accessible to all trainees on a regular and ongoing basis. The training program shall have the capability to admit each applicant within thirty (30) days after the applicant's initial request for training.

(30) Termination of a Training Program. The training program or the department may terminate the training program by giving ninety (90) days written notice to the other party.

(31) Compliance. Failure to adhere to the stipulations, conditions, and requirements set forth in this rule shall be considered cause for revocation or denial of program certification.

(32) The following forms are included herein: (Contact SATOP section for a copy of these forms.)
(A) MO 650-7743;
(B) MO 650-7744; and
(C) MO 650-7745.

AUTHORITY: sections 302.540, RSMo Supp. 2001 and 577.001, 577.049, 577.520, 577.525, 630.050 and 630.053, 630.655 and 631.010, RSMo 2000. This rule originally filed as 9 CSR 30-3.760. Original rule filed Nov. 2, 1987, effective May 15, 1988. Emergency amendment filed April 20, 1988, effective May 15, 1988, expired Aug. 31, 1988. Amended: Filed April 20, 1988, effective Aug. 31, 1988. Amended: Filed July 6, 1992, effective Feb. 26, 1993. Emergency amendment filed May 3, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency amendment filed Oct. 17, 1994, effective Oct. 28, 1994, expired Feb. 24, 1995. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Moved to 9 CSR 30-3.206 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed March 8, 2002, effective Sept. 30, 2002.*

**Original authority: 302.540, RSMo 1983, amended 1984, 1993, 1996, 2001; 577.001, RSMo 1982, amended 1986, 1996; 577.049, RSMo 1982, amended 1993, 1996; 577.520, RSMo 1987, amended 1991, 1993, 1996; 577.525, RSMo 1987, amended 1991, 1996; 630.050, RSMo 1980, amended 1993, 1995; 630.053, RSMo 1993, amended 1995, 1996; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.208 SATOP Supplemental Fee

PURPOSE: This rule establishes a supplemental fee which shall be collected by all certified Substance Abuse Traffic Offender Programs as required by state statute.

(1) Supplemental Fee. All Substance Abuse Traffic Offenders Programs shall collect from all applicants entering the program a sixty dollar ($60)-supplemental fee which shall be in addition to any other costs which may be charged by the program. The supplemental fee shall be collected no more than one (1) time from any individual who has entered SATOP, whether for assessment or for an educational program.

(2) Remittance of Supplemental Fees. On or before the fifteenth (15) day of each month program directors shall remit the total of all supplemental fees collected during the prior calendar month, less two percent (2%) which, by law, may be retained by the program to offset collection and remittance costs.
(A) Remittance shall be mailed to: Mental Health Earnings Fund, Controller, Department of Mental Health, 1706 East Elm Street, P.O. Box 596, Jefferson City, MO 65102.
(B) Transfer of supplemental fees from the program to the Mental Health Earnings Fund shall be in the form of a single check made payable to the Mental Health Earnings Fund.
(C) Program remittance checks shall be accompanied by a Supplemental Fee Remittance Form 9314 (to be provided by the Department of Mental Health at no cost to the program) which shall list the name and Social Security number of persons paying each supplemental fee being remitted.

(3) Documentation of Supplemental Fee Transactions. Each program shall maintain, at its principal administrative center, a single record of all supplemental fee transactions, which is separate from all other program records. This separate record will facilitate audits which may from time-to-time be conducted by the department or the state auditor's office. A separate program record of supplemental fee transactions shall include copies of monthly remittance forms and copies of checks forwarded to the Mental Health Earnings Fund.

(4) Acceptance of Supplemental Fees. The department shall accept supplemental fee remittances only from certified programs. Supplemental fee remittances, if received by the department from any agency not certified, will be returned to that agency. If an agency's certification has been revoked, the department will only accept supplemental fee remittances that were collected prior to the date the agency's certification was revoked. Remittances collected by the agency from clients after the date of the revocation shall not be accepted by the department. In such case, the supplemental fee must be returned to the client by the agency.

(5) Notice Posted. Programs shall post, in places readily accessible to persons served, one (1) or more copies of a Student Notice Poster which shall be provided by the department at no cost to the program. Posters shall explain the statutory requirement for the supplemental fees, disposition of supplemental fees, and the means by which programs collect and remit supplemental fees.

(6) Compliance. Failure to adhere to the stipulations, conditions and requirements set forth in this rule shall be considered cause for revocation of program certification.

(7) Form number MO 650-1017 is included herein. (Contact SATOP section for a copy of this form.)

AUTHORITY: sections 302.540, 577.001, 577.049, 577.520, 577.525, 630.050, 630.053, 630.655 and 631.010, RSMo 2000. This rule was originally filed as 9 CSR 30-3.790. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Moved to 9 CSR 30-3.208 and*

amended: Filed Feb. 28, 2001, effective Oct. 30, 2001.

**Original authority: 302.540, RSMo 1983, amended 1984, 1993, 1996; 577.001, RSMo 1982, amended 1986, 1996; 577.049, RSMo 1982, amended 1993, 1996; 577.520, RSMo 1987, amended 1991, 1996; 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.230 Required Educational Assessment and Community Treatment Program

PURPOSE: This rule identifies the Department of Mental Health as being responsible for the certification of Required Educational Assessment and Community Treatment programs as mandated by state statute.

(1) Mission. The Missouri Required Educational Assessment and Community Treatment (REACT) program is a statewide system of comprehensive, accessible, community-based education and treatment programs designed for individuals who have been found guilty of, or pled guilty to a Chapter 195 felony drug offense. The mission of REACT is—

(A) To promote a drug- and crime-free lifestyle;

(B) To provide education and/or treatment on the multi-faceted consequences of substance use;

(C) To explore intervention and treatment options; and

(D) To contribute to public health and safety in Missouri.

(2) Program Functions. REACT programs shall provide or arrange assessment screening; education; and treatment.

(3) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization providing REACT to demonstrate achievement of the program's mission and functions. Indicators can include, but are not limited to the following:

(A) Characteristics of persons participating in REACT such as type of offense, prior alcohol and drug offenses, prior treatment history, etc.;

(B) Consistent use of screening criteria including the rate at which persons are assigned to education and treatment programs;

(C) Rate at which persons successfully complete REACT;

(D) Reductions in alcohol and drug offenses among those who complete REACT; and

(E) Consumer satisfaction and feedback.

(4) Types of Programs. The department shall recognize and certify the following types of Required Educational Assessment and Community Treatment programs:

(A) REACT Screening Unit (RSU) which provides assessment screening including an individualized interview, recommendation and referral for further services for those coming under the purview of section 559.630, RSMo; and

(B) REACT Education Program (REP) which provides basic offender education over the course of ten (10) hours for lower risk first offenders to assist them in understanding the choices they made that led to their arrest and the resulting consequences. All persons completing this course shall develop a personal plan of action to assist them in preventing future offenses.

(5) Requirements for Program Certification. REACT programs shall comply with those rules and standards listed under 9 CSR 30-3.032 Certification of Alcohol and Drug Abuse Programs.

(A) Rules under 9 CSR 10-7.120 Physical Plant and Safety shall be applicable based on the type of services provided by the program and whether services are offered to individuals and groups at the program site. In addition—

1. The program must be located in an office, clinic or other professional setting;

2. Assessment screenings must be located in a setting which provides space for private, one-on-one interviews and ensures confidentiality. With the department's written approval, assessment screenings may be conducted at other locations on a limited basis, if confidentiality is assured and the individual agrees to a screening at the alternate site.

(B) The following rules and standards shall be waived for REACT programs, unless the department determines that a specific requirement is applicable due to the unique circumstances and service delivery methods of a program:

1. 9 CSR 10-7.010 Treatment Principles and Outcomes;

2. 9 CSR 10-7.030 Service Delivery Process and Documentation;

3. 9 CSR 10-7.060 Behavior Management;

4. 9 CSR 10-7.070 Medications;

5. 9 CSR 10-7.080 Dietary Services;

6. 9 CSR 30-3.100 Service Delivery Process and Documentation (ADA); and

7. 9 CSR 30-3.110 Service Definitions and Staff Qualifications (ADA).

(6) Other Requirements. Agencies certified as a Required Educational Assessment and Community Treatment shall follow the standards found in 9 CSR 30-3.200 through 9 CSR 30-3.210, unless otherwise specified in this rule. When reference is made to the Substance Abuse Traffic Offender Program (SATOP), it shall apply to the REACT program. When reference is made to SATOP Offender Management Unit (OMU), it shall apply to the RSU. When reference is made to the SATOP Offender Education Program (OEP), it shall apply to the REP.

(7) Assessment Screening Required. The program shall have written policies and procedures that stipulate the methods of assessment screening and the conditions under which referrals are made for further services.

(A) The written policies and procedures must follow the screening guidelines outlined by the Department of

Mental Health and the Department of Corrections.

(B) The program shall provide assessment screening and recommendation, where appropriate, to education or treatment.

(C) A program that provides assessment screening must also provide REP services.

(D) A person may request and attend a REP operated by a different agency due to reasonable circumstances, such as distance, work schedule or other time factors.

(E) A separate amount paid by the client shall cover the assessment screening in addition to the cost of the program.

(8) Qualifying Staff. A REACT program shall not employ, or sub-contract with any individual, nor themselves be currently, or within a two (2)-year period, under the supervision or jurisdiction of federal, state, county or local corrections or court system.

(9) Assessment Screening Process. All persons referred to REACT shall, prior to attending the education or treatment program, receive an individualized assessment screening to determine the need for treatment or education. The assessment screening process shall include:

(A) Demographic data collection;

(B) A standardized screening instrument;

(C) A face-to-face individualized assessment screening interview;

(D) A legible hand printed or typewritten screening report;

(E) Completion of the REACT Offender Assignment form and, when requested, a narrative report to the court;

(F) Minimal case coordination, when appropriate, to coordinate with the courts, probation and parole, or the Department of Corrections to verify that education, rehabilitation and treatment recommendations have been completed; and

(G) An assessment recommendation shall be delivered in writing to the person.

(10) Components of Assessment Screening. The assessment screening by the certified program shall follow basic guidelines established by the Department of Corrections (DOC).

(A) All clients shall complete a valid and reliable screening instrument approved by the DOC to identify problem users. The screening instrument shall be standardized, consistent statewide, and interpreted by certified qualified substance abuse professionals who are properly supervised and trained in the use of the screening device.

(B) All clients shall have an individualized assessment screening interview conducted by a qualified substance abuse professional.

1. The individualized assessment screening shall determine the extent of the problem (or lack of a problem) and the level or type of treatment or education services needed.

2. The assessment screening shall include, but not be limited to, a screening instrument summary including a substance use history, prior treatment history, summary of findings and a recommendation for either education or treatment based on minimum referral guidelines.

3. Collaborative information, such as previous treatment information and contacting significant others, may be obtained with proper authorization when appropriate.

(11) Quality Recommendations. The program must develop assessment screening recommendations that are—

(A) Impartial and solely based on the needs of the offender and the welfare of society; and

(B) Never used as a means of case finding for any particular treatment program or as a marketing tool for any REACT program.

(12) Referral Guidelines. The program must base the assessment screening recommendation and referral plan for each person on the following referral guidelines:

(A) REP education unless a more intense program is indicated by such factors as other alcohol/drug related arrests, screening instrument recommendations, prior alcohol/drug treatment, or other occupational, relationship, or medical problems; and

(B) Persons with a serious mental illness should have their mental health treatment needs addressed before completing any REACT recommendation. A mental health evaluation should be arranged for those clients identified with serious emotional or mental health problems during the REACT assessment screening process. In order to promptly arrange the mental health evaluation, the REACT agency conducting assessment screenings must maintain a formal affiliation agreement with a certified community mental health center, state mental health facility, licensed psychiatrist, licensed psychologist, or licensed clinical social worker. The client may resume REACT participation upon stabilization of the problem as determined by the client's mental health provider.

(13) Assessment Screening Cost. The cost of the assessment screening, along with the sixty-dollar ($60) supplemental fee approved by the department, shall be paid by the client and should not be excessively greater than relative costs indicate and shall include the costs for any case coordination functions necessary to—

(A) Monitor the client's progress in either education or a treatment program(s); and/or

(B) Coordinate with the courts or probation and parole.

(14) Notice of Program Assignment and Completion. The agency that conducts the assessment screening for offenders shall provide a REACT Offender Assignment form and a REACT Report of Offender Compliance form regarding successful completion or unsuccessful completion of the education portion of the program.

(A) A referring probation and parole office shall be sent a REACT Offender Assignment form within one (1) week of the assessment screening and a REACT Report of Offender Compliance form

within one (1) week of program completion.

(B) A copy of the REACT Offender Assignment form and the Report of Offender Compliance form shall be sent to the Department of Mental Health.

(C) A copy of the REACT Offender Assignment form and the REACT Completion Certificate shall be given to the offender.

(15) Treatment Programs Recognized for REACT. When the assessment screening indicates the individual's need for treatment and rehabilitation, arrangements shall be made for the person to participate in such services. The department shall recognize the following types of treatment and rehabilitation programs for offenders:

(A) Certified or Accredited Alcohol and/or Drug Treatment and Rehabilitation Programs.

(16) Criteria for Successful Completion of Treatment. When the assessment screening process indicates and if the person is eligible, certified alcohol and drug treatment and rehabilitation programs may also provide services for offenders. In addition, such persons who complete certified treatment programs after being charged or adjudicated for their offense but prior to their RSP screening process, may substitute participation in these treatment programs under certain conditions. In order to be recognized by REACT as successfully completing treatment, the offender must have written verification from a certified treatment and rehabilitation program that he or she has—

(A) Participated as scheduled in treatment services on a residential and/or outpatient basis for a period of at least ninety (90) calendar days;

(B) Substantially achieved personal recovery goals; and

(C) Met any other program requirements for successful completion of treatment. Those persons presenting substance dependence with a history of multiple offenses must participate in one hundred sixty (160) hours of services during the treatment episode.

(17) Cost of Treatment. The offender shall be responsible for all costs related to the completion of the treatment programs referenced in or required by this rule subsequent to the RSP assessment screening.

(A) All offenders shall be required to pay an initial base amount determined by the Department of Corrections before applying the Standard Means Test in accordance with 9 CSR 10-1.016.

(B) The client shall be responsible for all costs related to treatment that are not reimbursed through a third-party payer, including the Department of Corrections, or the Standard Means Test process.

(C) Programs may develop long-term payment plans to reasonably assist the client in paying off any outstanding balances.

(18) Cost of the REP Education Program. The cost shall be determined and approved by the Department of Corrections and shall be paid by the offender and shall cover the cost of the REP education program.

(19) Review and Approval of Costs. All REACT screening and education fees approved by the Department of Corrections shall be periodically reviewed and adjusted, if necessary, based on the best interests of the offender, society and the programs.

(20) Curriculum Guide. The REP program shall be conducted in accordance with the current edition of the *OEP Missouri Curriculum Guide, REACT Addendum*. A program must specifically request and obtain approval from the division before deviating in any manner from the content and methods in the applicable *Missouri Curriculum Guide*.

(21) REACT Training Program. A certified training program must, in addition to following standards found in 9 CSR 30-3.206, provide training on REACT standards. Certified staff shall complete a written examination and demonstrate the knowledge necessary to conduct the REACT programs.

(22) Supplemental Fee. All REACT programs shall collect from all applicants entering the program a sixty-dollar ($60) supplemental fee which shall be in addition to any other costs that may be charged by the program. The supplemental fee shall be collected no more than one (1) time from any individual who has entered REACT, whether for assessment or for an educational program.

(23) Remittance of Supplemental Fees. On or before the fifteenth (15th) day of each month, program directors shall remit the total of all supplemental fees collected during the prior calendar month, less two percent (2%) which, by law, may be retained by the program to offset collection and remittance costs.

(A) Remittance shall be mailed to: Correctional Substance Abuse Earnings Fund, Department of Corrections, 2729 Plaza Drive, Jefferson City, MO 65102.

(B) Transfer of supplemental fees from the program to the Correctional Substance Abuse Earnings Fund shall be in the form of a single check made payable to the Correctional Substance Abuse Earnings Fund.

(C) Program remittance checks shall be accompanied by a Supplemental Fee Remittance Form (to be provided by the Department of Corrections at no cost to the program) which shall list name and Social Security number of persons paying each supplemental fee being remitted.

(24) Documentation of Supplemental Fee Transactions. Each program shall maintain, at its principal administrative center, a single record of all supplemental fee transactions, which is separate from all other program records. This separate record will facilitate audits that may from time-to-time be conducted by the Department of Mental Health, the Department of Corrections, or the state auditor's office. A separate program record of supplemental fee transactions shall include copies of monthly remittance forms and copies of checks forwarded to the Correctional Substance Abuse Earnings Fund.

(25) Acceptance of Supplemental Fees. The Department of Corrections shall accept supplemental fee remittances only from certified programs. Supplemental fee remittances, if received by the department from any agency not certified, will be returned to that agency. If an agency's certification has been revoked, the department will only accept supplemental fee remittances that were collected prior to the date the agency's certification was revoked. Remittances collected by the agency from clients after the date of the revocation shall not be accepted by the department. In such case, the supplemental fee must be returned to the client by the agency.

(26) Notice Posted. Programs shall post in places readily accessible to persons served, one (1) or more copies of a Student Notice Poster that shall be provided by the Department of Corrections at no cost to the program. Posters shall explain the statutory requirement for supplemental fees, disposition of supplemental fees, and the means by which programs collect and remit supplemental fees.

(27) Compliance. Failure to adhere to the stipulations, conditions, and requirements set forth in this rule shall be considered cause for revocation of program certification.

AUTHORITY: sections 559.630, 559.633, 559.635, 630.050, 630.655 and 631.010, RSMo 2000. This rule originally filed as 9 CSR 30-3.800. Original rule filed Oct. 16, 1998, effective March 30, 1999. Moved to 9 CSR 30-3.230 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 559.630, RSMo 1998: 559.633, RSMo, 1998; RSMo 1998: 630.050, 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.300 Prevention Programs

PURPOSE: This rule identifies the expected outcomes, strategies and operational requirements for prevention programs.

(1) Program Description. A prevention program offers a planned, organized set of activities designed to reduce the risk of and incidence of illegal or age-inappropriate use or abuse of alcohol, tobacco and drugs.

(A) Prevention activities and services are provided to an identified target population within a designated geographic area.

(B) The target population may include individuals, groups, organizations, communities, and the general public. The target population may include individuals or groups considered to be at-risk or high-risk in their potential for substance use; however, prevention activities are not specifically or primarily directed to persons who need treatment for substance abuse.

(C) A prevention program shall provide services that are comprehensive, research based and culturally sensitive and relevant.

(D) A prevention program should serve all age groups and populations, including special populations.

(2) Use of Risk Reduction Strategies. A prevention program shall implement strategies which reduce the risk of and the incidence of illegal or age-inappropriate use or abuse of alcohol, tobacco and drugs. The program shall implement the following risk reduction strategies in accordance with the type of prevention services and programming it offers:

(A) Increase awareness of the nature and extent of such substance use or abuse and their effects on individuals, families, and communities;

(B) Inform others about available prevention and treatment services;

(C) Develop social and life skills which reduce the potential for such substance use or abuse;

(D) Provide constructive and healthy activities to offset the attraction of such substance use or abuse or to meet needs which otherwise may be fulfilled by these substances;

(E) Identify persons who may have become involved in the initial, inappropriate or illegal use of alcohol, tobacco, and drugs and then arrange support and other referrals, as needed;

(F) Assess community needs and assist in the development of community planning and action;

(G) Establish or change community attitudes, norms and policies known to influence the incidence of such substance use or abuse;

(H) Actively intervene with individuals and populations who have multiple risk factors for such substance use or abuse; and

(I) Organize, coordinate, train and assist other community groups and organizations in their efforts to reduce such substance use or abuse.

(3) Types of Certified Programs. An agency may be certified to provide one (1) or more of the following types of prevention programs:

(A) Primary Prevention Program;

(B) Targeted Prevention Program; or

(C) Statewide Prevention Resource Center.

(4) Requirements for Certification. A prevention program shall comply with those rules and standards listed under 9 CSR 30-3.032 Certification of Substance Abuse Programs.

(A) Requirements under 9 CSR 10-7.120 Physical Plant and Safety shall be applicable based on the type of services provided by the prevention program and whether services are offered to individuals and groups at the program site.

(B) The following rules and standards shall be waived for prevention programs, unless the department determines that a specific requirement is applicable due to the unique circumstances and service delivery methods of a program:

1. 9 CSR 10-7.010 Treatment Principles and Outcomes;

2. 9 CSR 10-7.020 Rights, Responsibilities and Grievances;
3. 9 CSR 10-7.030 Service Delivery Process and Documentation;
4. 9 CSR 10-7.060 Behavior Management;
5. 9 CSR 10-7.070 Medications;
6. 9 CSR 10-7.080 Dietary Services;
7. 9 CSR 30-3.100 Service Delivery Process and Documentation (ADA); and
8. 9 CSR 30-3.110 Service Definitions and Staff Qualifications (ADA).

(5) Qualifications of Staff. Services shall be provided by a qualified prevention specialist who demonstrates substantial skill by being—

1. A graduate of an accredited college or university with a bachelor's degree in community development, education, public administration, public health, psychology, sociology, social work or closely related field and have one (1) year or more of full-time equivalent professional experience in education, public health, mental health, human services, or a closely related area. Additional years of experience may be substituted on a year for year basis for the education requirement; or
2. An alcohol and drug abuse prevention professional credentialed by an agent acceptable to the department.

(6) Documentation of Resources and Services. All prevention programs shall maintain—

(A) A current listing of resources within the geographic area in order to readily identify available substance abuse treatment and prevention resources, as well as other resources applicable to the target population;

(B) Informational and technical materials that are current, relevant and appropriate to the program's goals, content, and target population.

1. Materials and their use shall accommodate persons with special needs, or the materials can be readily adapted to meet those needs.
2. Materials shall be periodically reviewed by staff and advisory board to ensure relevance to the target population and consistency with current prevention research. The advisory board shall include members of the target population and a broad range of representatives from other community groups and organizations; and

(C) A record of all service activities. The record shall—

1. Identify the presenter and participants;
2. Describe the service activity;
3. State how the activity meets the specific needs of the individual, group, or community organization served;
4. Include consents for participation or releases of information, as applicable; and
5. Include or summarize participant evaluations, as applicable.

(7) Primary Prevention Program. A Primary Prevention Program shall offer comprehensive services and activities to a specified target population(s) in its effort to reduce the risk of and incidence of illegal or age-inappropriate use or abuse of alcohol, tobacco and drugs.

(A) A primary prevention program shall offer all of the following types of prevention services: information, education, alternatives, problem identification and referral, community-based process, and environmental services.

1. Unless otherwise indicated, the target population for information, education, alternatives, and problem identification and referral services shall include, but is not limited to, one (1) or more of the following: persons who are at risk for substance abuse; families or friends, or both, of persons at risk for a substance abuse problem; school officials or employers of persons at risk for a substance abuse problem; caretakers and families of elderly or populations with other special needs.
2. Unless otherwise indicated, the target population for community-based process and environmental services shall include, but is not limited to, persons at risk for substance abuse; community groups mobilizing to combat substance abuse, include civic and volunteer organizations; church; schools; business; healthcare facilities and retirement communities; state and municipal governments; and other related community organizations.

(B) Information services shall increase awareness of the nature, extent, and effects of such substance use or abuse.

1. Information services are characterized by one (1)-way communication from the presenter to the target population.
2. In addition to the target populations listed in subsection (7) (A), the target population formation services may include the general public.
3. Examples of information service activities include: distributing written materials such as brochures, pamphlets, newsletters, resources directories, and other relevant materials; distributing audiovisual materials such as films, tapes, public service announcements and other relevant materials; functioning as information resource center or clearinghouse; arranging speakers and presentations; and operating as a designated access point for computerized information networks.

(C) Education services shall develop social and life skills, such as conflict resolution, decision-making, leadership, peer resistance and refusal skills.

1. Education services are characterized by interaction between the facilitator and the participants to promote certain skills and behaviors.
2. Examples of education service activities include classroom or small group sessions for person of any age, peer leader and helper programs, and parenting and family management classes.

(D) Alternatives shall provide healthy and constructive activities to offset the attraction of such substance use or abuse or to meet needs which otherwise may be fulfilled by these substances.

1. Alternative services engage the target population in recreational and other activities that exclude such substance use or abuse.
2. Examples of alternative service activities include developing and supporting alcohol- and drug-free dances and parties, community service activities, teen institutes and other leadership

training and activities for youth, adults, parents, school faculty, or others.

(E) Problem identification and referral services shall assist in arranging support, education and other referrals, as needed, for persons who have become involved in the initial, inappropriate or illegal use of alcohol, tobacco, and drugs.

1. This service does not include a professional or comprehensive assessment and determination of the need for substance abuse treatment.

2. Examples of specific problem identification and referral activities include training and consultation to student assistance programs, employee assistance programs, medication support programs for the elderly and other programs and organizations that may intervene with persons in the target population.

(F) Community-based process shall involve the assessment of community needs and the promotion of community planning and action in order to enhance other prevention and treatment services and to reduce the incidence of such substance use or abuse.

1. The target population shall include community action teams, such as Community 2000 Teams. A community action team must have broad-based community representation and participation, such as civic organizations, neighborhood groups, churches, schools, law enforcement, healthcare and substance treatment facilities, businesses, and governmental organizations.

2. Examples of community-based process activities include assessing community needs and risk factors and recruiting, training, and consulting with community action teams.

(G) Environmental services shall positively affect community policies, attitudes, and norms known to influence the incidence of such substance use or abuse.

1. Environmental services may address legal/regulatory initiatives, service/action initiatives, or both.

2. Examples of environmental services include maintaining current information regarding environmental strategies; training and consulting with community action teams in the development and implementation of such strategies; serving as a resource to school, businesses, and other community organizations in the development of policies; and providing information regarding alcohol and tobacco availability, advertising and pricing strategies.

(8) Targeted Prevention Program. A Targeted Prevention Program shall actively intervene with individuals and populations that have multiple risk factors for the illegal or age-inappropriate use or abuse of alcohol, tobacco and drugs. The program shall reduce risk factors and reduce the likelihood of such substance use or abuse.

(A) The target population shall include:

1. Persons at risk of substance abuse, such as out-of-school youth, youth dropouts, or persons prone to violence; and

2. Individuals and groups that influence those persons at risk for substance abuse, such as parents; teachers, families and caretakers of elderly or populations with other special needs; and school based and community groups, including civic and volunteer organizations, churches and other related community organizations.

(B) The program may be located in school or other community settings.

(C) The program shall provide and promote social and emotional support, skill development, counseling, and other preventive services for persons and populations with multiple risk factors.

(D) Examples of specific services and activities include early identification and intervention; efforts to prevent dropping out of school; after-school recreational and educational activities; development of social and life skills such as conflict resolution, decision making, leadership, peer resistance and refusal skills; group counseling or individual counseling, or both; parent training and consultation with school staff or other community organizations.

(9) Prevention Resource Center. A prevention resource center shall organize, coordinate, train, assist and recognize community, regional and state resources in their efforts to reduce the illegal or age-inappropriate use or abuse of alcohol, tobacco and drugs.

(A) The target population shall include community action teams, such as Community 2000 Teams; other community organizations including primary prevention program; and other community and state resources.

(B) Examples of specific activities include:

1. Conducting statewide and regional workshops and conferences;

2. Where applicable, distributing a state-wide newsletter that contains current information about prevention activities and issues;

3. Providing information and technical assistance regarding effective prevention strategies that are based on research findings;

4. Recognizing accomplishments by community action teams and sponsoring recognition events;

5. Coordinating prevention activities and resources development with other state level organizations and state agencies; and

6. Expanding and strengthening the network of community and state organizations involved in prevention activities.

AUTHORITY: section 630.655, RSMo 2000. This rule was originally filed as 9 CSR 30-3.630. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded and readopted: Filed June 27, 1995, effective Dec. 30, 1995. Moved to 9 CSR 30-3.300 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Oct. 15, 2001, effective April 30, 2002.*

**Original authority: 630.655, RSMo 1980.*